DOCUMENT RESUME

ED 263 225	UD 024 275
TITLE	Teenage Pregnancy and Parenting Project. 1983-84 Annual Report and Evaluation.
INSTITUTION	California Univ., San Francisco. Inst. for Health Policy Studies.; San Francisco Family Service Agency, CA.
SPONS AGENCY	Office of Adolescent Pregnancy Programs (PHS), Washington, DC.
PUB DATE	85
NOTE	154p.; For related document, see UD 024 064.
PUB TYPE	Reports - Evaluative/Feasibility (142)
EDRS PRICE	MF01/PC07 Plus Postage.
DESCRIPTORS	*Adolescents; *Counselor Role; Dropout Prevention; *Early Parenthood; Health Services; High Schools; Pregnancy; *Pregnant Students; *Program Effectiveness; Program Evaluation; Social Services; Unwed Mothers
IDENTIFIERS	California (San Francisco); *Case Management; *Teenage Pregnancy and Parenting Project CA

ABSTRACT

The Teenage Pregnancy and Parenting Project (TAPP) of San Francisco is a city-wide interagency service system coordinated by the city's Family Service Agency and Unified School District. Clients participate in pre- or post-natal service systems that provide free, personal, and continuous counseling for up to three years. Case managers identify and assess clients, plan services, link clients with needed services, monitor service delivery, and provide client advocacy. Major findings of TAPP's evaluation for 1983-84 were the following: (1) TAPP, in its third year of operation, showed an increased number (271) and type of referrals, reflecting the development of a network of professional contacts and the program's positive city-wide acceptance; (2) TAPP's Fatherhood Project, in operation since 1983, has had a significant impact in increasing the participation of adolescent fathers; (3) the majority of TAPP clients were between 15 and 17, and 67% lived with their parents; (4) of clients leaving the program in 1983-84, 25% left with "self-sufficiency" status; (5) babies born to participating teens were higher in weight than babies born to non-participating teens, but improvements in birth outcomes are still necessary; (6) significantly more female clients who were not enrolled in school at entry to TAPP attended school during pregnancy than remained dropouts; and (7) case managers were found to play a major role in the positive impact of the TAPP project. (KH)

****
*   Reproductions supplied by EDRS are the best that can be made   *
*   from the original document.   *
****

BEST COPY AVAILABLE

TEENAGE PREGNANCY & PARENTING PROJECT

1983-84 ANNUAL REPORT & EVALUATION

ED263225

U.S. DEPARTMENT OF EDUCATION
NATIONAL INSTITUTE OF EDUCATION
EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)

✓ This document has been reproduced as received from the person or organization originating it.
Minor changes have been made to improve reproduction quality.

- Points of view or opinions stated in this document do not necessarily represent official NIE position or policy.

"PERMISSION TO REPRODUCE THIS MATERIAL HAS BEEN GRANTED BY
Amelia B. Williams
Family Service Agency of San Francisco. TAPP.
TO THE EDUCATIONAL RESOURCES INFORMATION CENTER (ERIC)."

FAMILY SERVICE AGENCY OF SAN FRANCISCO

In co-location and cooperation with

CHILDREN'S HOME SOCIETY OF CALIFORNIA
SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH
SAN FRANCISCO DEPARTMENT OF SOCIAL SERVICES
SAN FRANCISCO UNIFIED SCHOOL DISTRICT
UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
AT SAN FRANCISCO GENERAL HOSPITAL
Dept. of Obstetrics, Gynecology, & Reproductive Sciences

UD 024 275

Evaluated by

UNIVERSITY OF CALIFORNIA, SAN FRANCISCO
Center for Population & Reproductive Health
Institute for Health Policy Studies

A United Way Member Agency

ACKNOWLEDGEMENTS

The Teenage Pregnancy and Parenting Program wishes to thank the following organizations for their financial and staff support:

- Bank Street College of Education, New York
- Center for Population and Reproductive Health, Institute of Health Policy Studies, U.C.S.F.
- Federal Office of Adolescent Pregnancy Programs, Department of Health and Human Services
- Ford Foundation
- Maternal and Child Health Branch, Department of Health Services, State of California
- San Francisco Department of Public Health
- San Francisco Department of Social Services
- San Francisco Foundation
- San Francisco Unified School District

Special thanks are expressed to the many network agencies which make this comprehensive service delivery system possible. Agencies with formal linkage agreements with T.A.P.P. include:

Advocates for Women
Alamo Park High School
Audrey L. Smith Child Care/Respite Care
Caheed Child Care
Catholic Social Services
Children's Council of San Francisco
Children's Home Society
Community Mental Health Department
Compañeros del Barrio
Directions
District Attorney's Office
Early Parenting Project
Emergency Food Box
Family Development Center
Florence Crittenton Services
Hastings Childcare Center
Health Center #3
Health Clinic at Youth Guidance Center
Infant Parent Program
Legal Services for Children
Mission Hiring Hall
Mission Neighborhood Health Center
Mt. Zion Special Service Center
Native American Health Center
Private medical providers
Real Alternatives Program (RAP)
St. Elizabeth's Special Service Center
San Miguel Infant Center
Student Attendance Review Board (SARB)
Sunshine High School
UCSF/SFGH
Volunteer Center
Youth for Service
Youth Guidance Center

TABLE OF CONTENTS

PROJECT REPORT — Page No.

Program Summary — i - v

Case Management Methodology — vi -xv

TAPP Two Year Outcomes — xvi

Number of Clients Served — xvi

EVALUATION

Executive Summary — 1 - 13

PART I - Client Demographics at Entry - 1983 - 1984

Comparison with Earlier Years of the Tapp Project — 14

Problem Statement.................................... 14

Intervention Strategies.............................. 15

Evaluation Goal...................................... 16

Entry Status... 18

Age of Client.. 18

Ethnicity and Language............................... 22

Marital Status and Living Arrangements............... 25

Previous Pregnancies................................. 25

School Enrollment at Entry........................... 29

Employment and Welfare Status........................ 34

Court Dependency/Probation Status..................... 37

Reasons for Referral to TAPP......................... 39

Residence of New TAPP Clients........................ 44

Profile of Clients' Partners......................... 47

Profile of Exited Clients............................ 49

Implication of Results/Findings...................... 52A

PART II - EVALUATION OF OUTCOMES...................... 53

LOW BIRTHWEIGHT BIRTHS to TEENS in TAPP.......... 53

Problem Statement.................................... 53

Intervention Strategy................................ 53

Evaluation Methodology - Objectives and Hypothesis....... 53

Data and Analysis.................................... 54

A. Results:

Comparison of Rates of Low Birthweight Births by Case Management Tracks................................ 55

Comparison of Rates of Low Birthweight Births for Different Characteristics of Pregnant Teens........... 58

Comparison of Rates of the Characteristics Associated With Low Birthweight Births In the Case Management Schooling Tracks ... 62

Implications of Results ... 66

School Continuation Rates for Female Clients Pregnant At Entry To TAPP ... 68

Problem Statement ... 68

Intervention Strategy ... 68

Evaluation Methodology - Objectives and Hypothesis ... 68

Data and Analysis ... 68

Results:

Comparison of School Status at Entry With School Status while Pregnant ... 70

Comparison of School Status at Seven Months After Births with School Status while Pregnant ... 70

Comparison of School Status at One Year After Birth with School Status while Pregnant ... 74

Comparison of School Status One Year After Birth by School Status Seven Months After Birth ... 74

Comparison of Demographic Characteristics of School Dropouts and Those Clients in School ... 77

Implication of Results ... 77

Repeat Pregnancy Rates for Female Teens in TAPP ... 80

Problem Statement ... 80

Intervention Strategy ... 80

Evaluation Methodology - Objective ... 80

Data and Analysis ... 80

Results ... 80

Implications of these Results ... 81

PART III - CASE MANAGEMENT STUDY - 1983-1984 ... 82

Background ... 82

Defining Case Manager ... 85

Results:

Case Manager Work Characteristics ... 87

Teen Fathers ... 89

TABLES/FIGURES

Table Number		Page Number
1	Statistical Profile of New Clients enrolled Through September 30, 1984	19
2	Age by Entry Status of New Clients, 1982-83 and 1983-84	20
3	Ethnic Distribution by Entry Status 1982-83 and 1983-83	23
4	Language Spoken by Entry Status 1982-1983 and 1983-1984	24
5	Marital Status by Entry Status 1982-1983 and 1983-1984	26
6	Living Arrangements by Entry Status 1982-1983 and 1983-1984	27
7	Number of Previous Pregnancies by Entry Status 1982-1983 and 1983-1984	28
8	School Enrollment by Entry Status, 1982-83 and 1983-84	30
9	Length of Time Dropped Out of School, by Age, Entry Clients, 1982-83	31
9A	Length of Time Dropped Out of School, by Age For Pregnant and Entry Mother Clients 1982-83 and 1983-84	33
10	Employment by Entry Status 1982-83 and 1983-83	35
11	Welfare Status by Entry Status 1982-83 and 1983-84	36
12	Dependency/Probation Status by Entry Status 1982-83 and 1983-84	38
13	Referring Agencies or Sources for Entry Clients 1982-83 and 1983-84	40
13A	Referring Agencies or Sources for Pregnant Teen Clients, 1983-84	41
13B	Referring Agencies or Sources for Entry Mother Clients, 1983-84	42

Family Involvement 90
Role of Case Manager 92
Problems in Impimenting Case Management Role 97
Case Manager and Client Interactions 99
Client Needs 100
Conclusion 105

References 108

Appendix 110

Table Number		Page Number
13C	Referring Agencies or Sources for Male Clients, 1983-1984.	42
14	Within City Residence of New TAPP Clients by Health District - 1983-1984.	44
15	Age, Employment and School Enrollment of Partner, 1982-1983, 1983-1984.	48
16	Reason for Exiting by Entry Status, 1982-1983 and 1983-1984.	49
17	Time in Program of Exited Clients, by Entry Status, 1982-1983 and 1983-1984.	51
18	Incidence of low birthweight births (1983-1984) by Tracks based on the source of health care for the pregnant teen mother.	55
19	Incidence of low birthweight births (1983-1984) by school status of the pregnant teen mothers.	56
20	Average number of units of service per teen for the various services provided.	58
21	Incidence of low birthweight births (1983-1984) in various groups of pregnant teens.	60
22	Proportions of pregnant teens (1983-1984) with risk factors for low birthweight births by school status.	63
23	Ethnic differences of teen mothers in low birthweight births by school status.	65
24	School status at entry to TAPP of female clients in the various types of school programs while pregnant. Information is for all clients due for any stage of follow-up 1983-1984.	71
25	School status at seven months after birth by school status while pregnant in TAPP (determined "At Birth") for female followup cases in 1983-1984.	72

Table Number		Page Number
26	School status at one year after birth by school status while pregnant in TAPP (determined "At Birth") for female followup cases 1983-1984.	75
27	School status one year after birth by school status seven months after birth for female follow-up cases 1983-1984.	76
28	Demographic Characteristics of TAPP clients who are School Dropouts and those clients in School seven months after birth.	78

Case Management Study

Table 1	Case Manager Qualities as Ranked by TAPP Staff	93
Table 2	Role of Case Manager: Tapp Staff Ratio of Services Provided	94
Table 3	Case Manager's Major tasks By Frequency	96
Table 4	Case Management Strategies and their Occurence	101

TEENAGE PREGNANCY AND PARENTING PROJECT (TAPP)

Program Summary/Unique Features

TAPP is a city-wide inter-agency service system coordinated by the City's Family Service Agency and Unified School District. The primary site co-locates these agencies plus the Department of Social Services, Department of Public Health, Children's Home Society, and UCSF/SFGH-Ob/Gyn and Reproductive Sciences Department.

I. Multi-Track Service System

Clients participate in one of four pre- or post-natal service systems (tracks). The primary site provides health, education and social services. The Continuous Counselor assures that clients in all tracks receive core and supplemental services.

TAPP IS UNIQUE AND DISTINCTIVE IN THAT ALL SAN FRANCISCO PREGNANT AND PARENTING TEENS ARE ELIGIBLE FOR CASE MANAGEMENT SERVICES WITHOUT REGARD TO THE STATUS OF THEIR SCHOOL ENROLLMENT, HEALTH CARE PROVIDER OR INCOME LEVEL.

PRE-NATAL	POST-NATAL
Comprehensive Single Site	Comprehensive Single Site
1) Medical care and pregnant minor program at same site: Mt. Zion School/ Mt. Zion Medical Center	1) School and daycare at single site: Sunshine/FDC Balboa/San Miguel Hilltop/E. W. Grady Nursery Mt. Zion St. Elizabeth's
Partial Single Site	Partial Single Site
2) Medical care at Mt. Zion; school off medical site: a. Other school b. Not in school c. Graduated	2) School and daycare at separate sites: a. Group daycare b. Licensed family daycare c. Unlicensed client arranged d. No daycare or work and daycare as above
3) Medical care off pregnant minor program sites (Hilltop, Mt. Zion and St. Elizabeth's)	3) Daycare at one site; no school or work (ie., temporary condition or client receiving respite care)
All Off-Site	All Off-Site
4) Medical care and school elsewhere: a. Other school b. Not in school c. Graduated	4) No school and no daycare

May 3, 1985

II. Continuous Counselling

Continuous Counselors are the backbone of the TAPP Project. Their primary function is to provide personal and continuous case management to clients. They serve as primary contacts in order to personalize the relationship between client and service network, facilitate service delivery, and conduct follow up to ensure that services are received. The Continuous Counselor maintains a relationship with the client for up to three years or until the client is approximately nineteen years of age.

a. Information and Referral

An information and referral system is available to clients who are not eligible for the program. The TAPP intake person links these clients with appropriate community services, including the co-located agencies.

b. Families

The Continuous Counselor works closely with the extended family to provide the appropriate support for the adolescent. Extended family members also attend support groups at TAPP.

c. Support Groups

Support groups are facilitated by the Continuous Counselor at the TAPP primary site and at three satellite sites: Balboa High School, Alamo Park Alternative High School, and Sunshine Alternative High School. Both pregnant teens and teen parents participate in these groups.

d. Fatherhood

An additional component ensures that young fathers receive comprehensive services with the Continuous Counselor providing case management. The Fatherhood Project uses a community worker and peer counselors who do outreach to young fathers. They receive the same services as the teen females. In addition, the Fatherhood Project addresses removal of barriers (health, school, legal and social) that prevent young fathers from receiving services that enhance their fathering capabilities. The fatherhood component includes fathers support groups, life skills classes specifically geared to fathers and recreational activities for fathers and their babies.

At the conclusion of the second year of the TAPP fatherhood project, TAPP has served 131 young fathers as core clients in the program. TAPP has also served, in some capacity, approximately 70 other young fathers on an informal basis. Thus, TAPP has been involved in the lives of 200 fathers in the first two years of the fatherhood project.

BEST COPY AVAILABLE

III. Innovative Coordination Components

a. Co-location

At the TAPP primary site, clients in all tracks receive a spectrum of services provided by workers from both public and private agencies:

1. Education - Hilltop Special Service Center

The SFUSD Hilltop program is part of the comprehensive single site. It provides all courses necessary for high school graduation. Support groups and other ancillary classes (nutrition, health education, child development, career education) are available to Hilltop students and other TAPP clients. Elaine Wolfe Grady Nursery provides infant daycare for 12 infants. TAPP has successfully enrolled expectant fathers and teen fathers into the pregnant minor program.

2. Public Health Nurses

The Public Health Nurse co-located at TAPP one and a half days each week, ensures that all clients are referred to the appropriate home visiting Public Health Nurse and coordinates public health services with the Continuous Counselor. Two public health nurses provide health education classes twice a week during the school semester.

3. Department of Social Services

The TAPP Co-locator from the Department of Social Services (DSS) functions as consultant and coordinator to staff and provides services to clients, including participating in joint home visits with the Continuous Counselors. The Co-locator is at TAPP one day per week.

4. Nutrition Services

The TAPP Nutritionist is on-site one and a half days per week. She provides individual nutrition counseling and assessment and nutrition classes at the primary site. In addition, the nutritionist is at the San Francisco General Hospital Teen OB/GYN Clinic a half day a week doing assessment & follow-up.

5. Adoption

The Children's Home Society (CHS) Co-locator provides individual and group counseling to clients and consultation and training to staff, every other week.

b. Liaison Relationships

Continuous Counselors provide liaison relationships on an ongoing basis to both health and education sites, where a large portion of TAPP clients are served. Currently, the liaison sites are:

1. Mt. Zion Special Service Center

   A Continuous Counselor meets regularly with Mt. Zion staff to coordinate services to TAPP clients attending Mt. Zion school, an average of ten (10) hours per week.

2. Teen OB Clinic/SFGH

   Clients at San Francisco General Hospital Teen OB Clinic are seen weekly and assessed for enrollment in TAPP. Ongoing counseling is provided to all TAPP clients by the Counselor at the clinic. Liaison with clinic staff includes participation in the weekly case reviews.

3. Teen Well Baby Clinic/SFGH

   The TAPP liaison to the San Francisco General Hospital Teen Well Baby Clinic participates in weekly case review meetings and shares information between Continuous Counselors and the social service and health providers.

4. Health Center 3

   TAPP added another liaison site to its services in July 1984. An average of 12-15 clients are seen by the liaison at the Prenatal Clinic held ½ day per week.

c. Satellite Sites - School and Infant Daycare Support Services

TAPP is currently providing services at three high schools which have a high percentage of teen parents. These services include: 1) co-facilitating teen parent support groups; 2) counseling pregnant teens and teen parents; and 3) coordinating TAPP services with site staff. Liaison functions are usually provided by Continuous Counselors.

1. Balboa High School/San Miguel Parent Infant Program

   There are approximately 50 teen parents enrolled at Balboa and 14 daycare slots in the Infant Center. The TAPP Community Outreach Worker and a Balboa School Counselor/Social Worker co-facilitate a weekly teen parent support group. Twenty two teen parents (5 pre-natal and 17 post-natal) were enrolled in this group. The TAPP liaison enrolls new clients, does classroom presentations and maintains coordination with the San Miguel Infant Center.

2. Alamo Park High School

   The TAPP liaison co-facilitates a teen parent support group with the School Counselor and a Public Health Nurse. The group meets weekly with 12 teens (2 pre-natal and 10 post-natal). Students participating in this group/class earn 5 semester credits. The TAPP liaison coordinates other TAPP services to approximately 15 clients enrolled in the school.

3. Sunshine High School/Family Developmental Center

The TAPP liaison co-facilitates a weekly teen parent support group with the school's Career Counselor. There were 15 teen parents enrolled in the group/class and they earned 1 semester credit for every 10 sessions attended. In addition, the Counselor maintained weekly coordination with Family Developmental Center (FDC), and infant daycare program located in the same building. Out of 75 infant slots, teen parents use approximately 34. The TAPP liaison met regularly with the FDC staff to review the 28 TAPP clients enrolled in the center and the status of the approximately 18 TAPP clients on the waiting list.

d. Network

1. Pregnant Teen and Teen Parent Network Meetings

Network meetings are held at TAPP once a month. Both linkage agency staff and TAPP staff attend these meetings. The meetings are informal in nature, with presentations to promote awareness of the many needs of pregnant teens and teen parents and to provide updates on new programs, legislation and research issues. Topics have included: Couples counseling, family violence, school attendance issues, child abuse, adolescent medicine, and career counseling.

2. San Francisco Perinatal Forum

As a member of the San Francisco Perinatal Forum, TAPP plays an active role in the Forum and in a variety of subcommittees of the Forum. Subcommittees include data, health education, psycho-social and funding criteria. This has strengthened our networking with perinatal providers in San Francisco and our program planning effectiveness.

e. Case Conferences

Another component of coordination is the interdisciplinary case conference, which is coordinated by the TAPP Continuous Counselors and includes staff from appropriate agencies serving the client. Clients and family members are routinely invited to participate in these conferences. An average of three case conferences are held each month.

CASE MANAGEMENT METHODOLOGY

1. Case Management Overview

The Underlying premise of TAPP is the case management system. This can be defined as a strategy for coordinating the provision of services to pregnant and parenting teen clients. The methodology of case management includes the coordination of services at both the systems and client level.

At the systems level it reflects policies and procedures that enhance comprehensive service delivery wherever the client is in the system (public or private health care, in or out of school, in or out of residential care, on or off welfare, etc.). In TAPP this systems coordination and policy making is done by co-located agency staff in conjunction with their respective agency administration (see network chart). An inter-agency administrative coordinating body meets periodically to review relevant issues. It is composed of DSS, SFUSD, FSA, DPH, and SF Medical Society.

At the client level case management is a goal oriented process for assessing the need of an individual for particular services and then, obtaining those services. It is the function of the Continuous Counselor within the TAPP system to provide personal and continuous case management. It is ongoing, no matter where the client receives services in the system. It is not time limited. The Continuous Counselor maintains a relationship with the client until the youth is approximately eighteen or self-sufficient. The philosophy of TAPP is that the needs of individual clients are unique and will vary over time. Therefore the program must be flexible enough to be responsive to the client during the various stages of pregnancy and after the baby is born.

We believe that teen mothers and fathers should be encouraged to take an active role in developing life goals and making choices for themselves and their children. However the Continuous Counselor must be persistant in assisting youth to make the necessary linkages to services and to follow through.

The counseling relationship is key to successful case management. It includes individual counseling, family support and partner involvement in home, office and/or other agency contacts. Home visits are essential. TAPP counselors have found that involving the family and partners in the counseling process contributes to healthy and more supportive environments for mother, father and child. The counseling relationship can be seen theoretically on a continuum from service broker to therapist. Most of the relationships fall somewhere in between on this continuum and when therapy is indicated the client is referred for mental health services. However, short term therapeutic intervention is often part of the counseling relationship. TAPP counselors may use the weekly clinical hour, supervision and mental health consultations from outside agencies to help in their multiple roles.

Case management is provided by counselors in caseloads of no more than thirty-five clients. Teen fathers who are seventeen and under and want to be clients are considered a case and are part of this count; whereas male partners who are older and family members are considered part of the female's case and are not counted separately. Infants and children are also part of the case and not counted separately.

Monthly quality assurance reviews are held by management staff. Case conference summaries to include the Individual Health Plan (IHP) will be reviewed during this process.

In addition to the client focused case management function, TAPP counselors assume liaison responsibility for one satellite site to maintain systems coordination of all TAPP clients at that site. (see linkage agreements) They also co-facilitate support groups at the primary site or at one of the satellite sites (no more than one group per counselor).

2. Case Management Functions

In view of the wide range of services a teen enrolled in TAPP might need at any one time, the Continuous Counselor becomes the one person responsible for remaining in touch with the client, regardless of how many agencies get involved. The Continuous Counselor thus provides the "glue that binds" otherwise fragmented services into arrangements that respond to the unique and changing needs of clients.

There are six essential functions of Case Management. The Continuous Counselor needs to be able to balance these multiple roles which include:

* Client Identification and Outreach
* Individual Assessment
* Service Planning
* Linkage With Requisite Services
* Monitoring of Service Delivery
* Client Advocacy

CLIENT IDENTIFICATION AND OUTREACH

Although teen mothers are more likely than teen fathers to seek services, they may delay doing so due to fear of embarrassment about their pregnancy. Therefore, agressive outreach to and identification of high risk pregnant teens and the fathers is essential.

Pregnant teens are referred from community agencies, schools, courts, health clinics, and more frequently now through peers and previous clients. Primary sources for referrals are from the health and education sites where TAPP has co-located or liaison staff. For example: Irene, a TAPP Continuous Counselor, is co-located at Balboa School. A teacher asks her to speak to a particular student whom he/she suspects may be pregnant. Irene will try fo find this student and enroll her/him in TAPP.

Many pregnant youth cannot be identified from school contacts. A study in San Francisco showed 23% females and 37% males are school dropouts at conception. The TAPP outreach worker is particularly crucial in locating pregnant teens who have already dropped out of school.

Special emphasis is placed in TAPP on locating the father, because involving them in the process helps support the teen mother in following through with pre-natal care. The outreach worker uses a streetwork approach to locate fathers and to establish rapport in a non-threatening, non-judgmental atmosphere.

The outreach worker is also valuable in finding youth enrolled in TAPP whose counselors are unable to locate them due to loss of telephone service or change in address. The outreach worker is street wise and street skilled and can often make the difference in obtaining a healthy outcome for the teen parent.

While the outreach worker may be the first contact with TAPP, once the youth is enrolled, he/she is assigned to a Continuous Counselor. It is important that partners have different counselors.

Co-locators, outreach workers and Continuous Counselors function as a team in finding and maintaining a pregnant teen and teen parent in the TAPP program. Once again, it is the client who is the center of the service delivery system and all staff are expected to work together to ensure that the individual gets what he/she needs.

INDIVIDUAL ASSESSMENT AND SERVICE PLANNING

The Needs Assessment process begins for every client upon entry to TAPP and continues throughout the duration of the client's relationship to the Continuous Counselor. The Intake Worker begins this process, but the Continuous Counselor asigned to the client will augment the initial assessment as he/she gets to know his client and makes referrals for services. Other providers of services, either on site at TAPP or off site, contribute to the overall needs assessment. For example, the medical assessment would be performed at a clinic site or private physician's office, while the nutrition assessment might take place at the TAPP offices or in a medical setting.

The Intake Worker explains the purpose of TAPP to an entering client. He/she makes it clear what TAPP can and cannot provide and explains to female clients that TAPP services are availbable to her partner as well. When a client is referred to TAPP, the Intake Worker is responsible for informing the referral source that the client was seen.

The Intake Worker explains/and completes the following forms:

* Public Health Nurse (PHN) Referral Form
* Nutrition Rererral Form
* Consent Form (to receive TAPP services)
* Release of Information (for sharing information between agencies)
* Case Management Service Delivery forms

The Intake Worker is responsible for arranging prenatal care and for doing an initial assessment on the client's school status. If the client is not in school, the worker begins the process to school re-entry. (Note: TAPP staff who are liaisons to particular school sites, do client intakes at that site.) the potential for involvement of the father is assessed at intake. If there is potential, the worker fills out a Fatherhood Outreach Referral form and gives it to the Supervising Counselor for case assignment.

The Intake Worker initiates the Case Management services delivery, making referrals for core services so that they will be delivered as quickly as possible. While it takes no more than a week before a permanent Continuous Counselor is assigned to the client, it is important that the referral process begin right away. If the Intake Worker assesses the client as a high risk case, the assignment to a Continuous Counselor may take place immediately. Until a case is assigned, the Intake Worker is the primary link to the client.

There are four case management guides for the four types of clients: pregnant female, expectant father, mother and father. As the client's needs change, the service plan can be modified. The Continuous Counselor and the client work together to select the most appropriate service providers. All TAPP clients must receive the essential Core Services designated for the prenatal and post natal phases. The Supplemental Services are determined by the Continuous Counselor and the client. Following are descriptions of Core and Supplemental Services for both teen mothers and fathers, for the pre-natal and post-natal phases. (see attachment)

Many TAPP clients attend special school programs for pregnant teens at Mt. Zion, St. Elizabeth's, or Hilltop at the TAPP site. Certain Core Services are thus more easily delivered because they are readily available. If the teen is not in school or in another school, greater care must be taken by the Continuous Counselor to assure health, nutritional education and related support services.

LINKAGE WITH REQUISITE SERVICES

In the TAPP Case Management system, it is essential that the Continuous Counselor actually link the teen client to necessary services. This requires more than just referring a client to a program, it requires doing whatever is necessary to get the teen to the service. It may mean driving someone to an appointment, providing busfare or asssisting the client through the admissions process. Substantial amounts of time may be used following up referrals and ensuring that clients actually received needed services. Clinical counseling intervention methods are de-emphasized and linkage/follow-up/brokerage activities are stressed in the relationship of the Continuous Counselor to the client.

TAPP uses both formal and informal mechanisms to ensure that a client is linked with another agency. The TAPP administrators develop formal interagency agreements which may involve TAPP staff liaisons to service providers or co-locatioon of TAPP staff at a particular site, or location of the service provider at a TAPP program site. The Continuous Counselor makes use of these coordinated systems for clients, and gives feedback to the supervisor as to their effectiveness as part of client advocacy function.

Another reason for establishing co-location of services is so that services can be clustered at locations most likely to be used by clients. Effective case management entails making needed services available and visible.

Once again, it is important to emphasize that the Continuous Counselor is not tied to any one system of service delivery, i.e., public health, a hospital, a maternity home, or a school. Rather, it is the role of the Continuous Counselor to assist the client in navigating these systems and getting the critical services which he/she needs.

MONITORING OF SERVICE DELIVERY

Monitoring of the service plan, or in other words, providing quality assurance, is another primary function of the TAPP Case Mangagement program. The objectives of the monitoring function are to assure that the client is receiving the expected services and that these services are necessary and appropriate for the client. This requires that the Continuous Counselor maintain ongoing contact with both the client and the service provider.

The monitoring function is designed to evaluate the client's progress towards meeting the objectives of the service plan and also provide the information necessary to make changes in that plan.

A formal Case Conference is an important strategy in monitoring service delivery which involves the participation of 3 or more agencies, e.g., the TAPP Continuous Counselor, Co-locator and a linkage agency. The client and her/his parent must be invited to these conferences, which can take place, whether or not the client or parent actually participate.

The Continuous Counselor may hold informal consultations about client progress with any of the service providers to whom he/she has made referrals. Both formal conferences and informal consultations help to determine the level of participation of the client, the effect of the service being provided and whether in fact the service is appropriate to the client's need.

Consultations may be held with other counselors and supervisors as a check on the soundness of decisions relating to service planning as well as to assess the overall effectiveness of a service delivery system.

CLIENT ADVOCACY

Advocacy for these youth, the mothers, fathers, babies and sometimes family members, must occur at two levels; the client level and the systems level.

At the Client Level, the advocacy function involves the Continuous Counselor assisting the client in receiving all the benefits to which he/she is entitled. The Continuous Counselor needs to be thoroughly familiar with eligibility criteria, application processes and appeals procedures for each needed service or program. The Continuous Counselor can then serve as an advocate towards removing obstacles or barriers to a client's receiving needed services.

The Continuous Counselor needs to empower the client to be her/his own advocate, so that they can learn to navigate effectively through the maze of institutions which make up life in the City. The Continuous Counselor must be careful not to allow his client to become dependent on her/him, but instead teach her/him the skills which will help her/him to be self-sufficient in each situation.

At the Systems Level, the advocacy function is ongoing: applying pressure to the system to make more services available or to recommend modifications to the system which will result in increased access to existing services for all TAPP clients.

TAPP PRE-NATAL SERVICES FOR MOTHERS

CORE:

☐ Childbirth Education
☐ Financial Needs Assessment
☐ General Health Care
☐ Maternity/Paternity Counseling
☐ Nutrition Assessment and Counseling
☐ Nutrition Education
☐ Parenting/Child Development Education
☐ Pre-Natal Health Care
☐ Pregnancy Test
☐ School Enrollment
☐ Substance Abuse Education

SUPPLEMENTAL:

☐ Adoption Counseling
☐ Alternative Birthing Classes (Childbirth Preparation Classes)
☐ Breakfast/Lunch Program
☐ Child Care
☐ Consumer Education
☐ Couple's Support Group
☐ Emergency Food Box
☐ Extended Family Member Counseling
☐ Extended Family Member Support Group
☐ Family Planning Counseling/Services
☐ Family Relationship Counseling
☐ Financial Assistance (AFDC/GA/Medi-Cal/SSI)
☐ Food Stamps
☐ Housing Assistance
☐ Job Training
☐ Legal Services
☐ Mental Health Services
☐ Partner Counseling
☐ Personal Counseling
☐ Public Health Nurse Services
☐ STD Test/Counseling/Treatment
☐ Teen Parent Support Group
☐ Transportation Assistance
☐ WIC/EOC

TAPP PRE-NATAL SERVICES FOR FATHERS

CORE:

☐ Childbirth Education
☐ Family Planning Counseling/Services
☐ Financial Needs Assessment
☐ General Health Care
☐ Nutrition Education
☐ Parenting/Child Development Education
☐ Paternity Counseling
☐ School Enrollment
☐ Substance Abuse Education

SUPPLEMENTAL:

☐ Adoption Counseling
☐ Alternative Birthing Classes (Childbirth Preparation Classes)
☐ Breakfast/Lunch Program
☐ Child Care
☐ Consumer Education
☐ Couple's Support Group
☐ Emergency Food Box
☐ Extended Family Member Counseling
☐ Extended Family Member Support Group
☐ Family Relationship Counseling
☐ Financial Assistance (AFDC/GA/Medi-Cal/SSI)
☐ Food Stamps
☐ Housing Assistance
☐ Job Training
☐ Legal Services
☐ Mental Health Services
☐ Partner Counseling
☐ Personal Counseling
☐ Public Health Nurse Services
☐ STD Test/Counseling/Treatment
☐ Teen Parent Support Group
☐ Transportation Assistance
☐ WIC/EOC
☐ Young Father's Support Group

TAPP POST-NATAL SERVICES FOR MOTHERS

CORE:

☐ Family Planning Counseling/Services
☐ Financial Needs Assessment
☐ General Health Care
☐ Mother's One Year Medical Check-up
☐ Nutrition Assessment/Counseling
☐ Nutrition Education
☐ Parenting/Child Development Education
☐ Paternity Counseling
☐ Post-Partum Check-up
☐ Post-Partum Home Visit
☐ School Enrollment
☐ Substance Abuse Education
☐ Well Baby Care

SUPPLEMENTAL:

☐ Adoption Counseling
☐ Breakfast/Lunch Program
☐ Child Care
☐ Consumer Education
☐ Couple's Support Group
☐ Emergency Food Box
☐ Extended Family Member Counseling
☐ Extended Family Member Support Group
☐ Family Relationship Counseling
☐ Financial Assistance (AFDC/GA/Medi-Cal/SSI)
☐ Food Stamps
☐ Housing Assistance
☐ Immunizations
☐ Job Training
☐ Legal Services
☐ Mental Health Services
☐ Partner Counseling
☐ Personal Counseling
☐ Pregnancy Testing
☐ STD Test/Counseling/Treatment
☐ Teen Parent Support Group
☐ Transportation Assistance
☐ WIC/EOC

TAPP POST-NATAL SERVICES FOR FATHERS

CORE:

☐ Family Planning Counseling/Services
☐ Financial Needs Assessment
☐ General Health Care
☐ Nutrition Education
☐ Parenting/Child Development Education
☐ Paternity Counseling
☐ School Enrollment
☐ Substance Abuse Education
☐ Well Baby Care

SUPPLEMENTAL:

☐ Adoption Counseling
☐ Breakfast/Lunch Program
☐ Child Care
☐ Consumer Education
☐ Couple's Support Group
☐ Emergency Food Box
☐ Extended Family Member Counseling
☐ Extended Family Member Support Group
☐ Family Relationship Counseling
☐ Financial Assistance (AFDC/GA/Medi-Cal/SSI)
☐ Food Stamps
☐ Housing Assistance
☐ Immunizations
☐ Job Training
☐ Legal Services
☐ Mental Health Services
☐ Partner Counseling
☐ Personal Counseling
☐ Post-Partum Home Visit
☐ STD Test/Counseling/Treatment
☐ Teen Parent Support Group
☐ Transportation Assistance
☐ Young Father's Support Group
☐ WIC/EOC

TAPP Two Year Outcomes

Low Birthweight Rates

1. The overall low birthweight rate for 1982-84 was 10.3% for females (N281) and 7.7% (N39) for males.

   The Pregnant Minor Program rate was 4.9% (N142).

   Students attending other schools or graduated has a 14.3% LBW rate (N49).

   School dropouts had a 16.7% LBW rate (N90).

Repeat Birth Rates

2. The repeat birth rate for female teens in TAPP one year after birth was 2% (N97); for female teens in TAPP two years after birth, the repeat birth rate was 10% (N55).

   The repeat birth rate for males in TAPP one year later was 2% (N92); for male teens in TAPP two years after birth the rate was 16.6% (N6).

School Enrollment Rates

3. For female teens who entered TAPP during their pregnancy, the school enrollment rate was 50% at entry (N274), 62% seven months after birth (N200) and 67% one year after birth (N97).

   The school enrollment rate for males was 58% at program entry (N74), 65% at birth (N26), 52% at seven months (N29), 50% one year after birth (N14).

4. Prior to TAPP enrollment at time of conception 23% of the pregnant teens were school drop-outs (N180) and 37% of the expectant fathers were drop-outs (N35).

Number of Clients Served October 1, 1983 - September 30, 1984

Pregnant	417
Non-pregnant	4
Entry mother	98
Male	111
Infants	402
Extended family members	556
Information and referral	57
TOTAL	1,645

EVALUATION

EXECUTIVE SUMMARY

The 1983-1984 evaluation of the Teenage Pregnancy and Parenting Project (TAPP) reviews the efforts of the program to meet the needs of high risk pregnant and parenting adolescents, as well as examines the impact of the project on key outcomes: 1) incidence of low birth weight births, 2) rates of school continuation for pregnant and parenting adolescents, and 3) rates of repeat births. A third component of the evaluation is a qualitative study of the role of the case managers in providing the key linkages which are necessary to provide comprehensive care city-wide.

I. Program Outreach Efforts and Trends in Client Demographics

In its third year, TAPP enrolled a total of 271 new clients. Nearly two-thirds of new clients were pregnant at entry, the most desirable condition since the greatest impact can be made on both the client(s) and her/his infant. An increasing number of clients are being referred to the TAPP project through schools, social service agencies, as well as through informal recommendations, while almost a third of all referrals continue to be made by health professionals. The increased number and type of referrals shown during this year reflects the network of professional contacts that has been developed by the TAPP project and its positive city-wide acceptance.

The city-wide network has enabled the program to reach and enroll clients from geographic locations within the city which are in highest need of services. Three of the five health districts in the city account for 65% of all adolescent births in San Francisco and were identified as being in highest need of services. In the previous year's program effort, TAPP was able to provide services to 43% of pregnant adolescent residing in these districts. This year there has been a significant effort to enroll clients from these districts and consequently, eighty percent of new clients reside within these areas (statistically significant at $P<.05$).

The Fatherhood Project, in operation since 1983, has had a significant impact in increasing the involvement of teen fathers in the project - nearly 20 percent of all clients were male in 1983-84, compared to 6 percent in previous years. Through this special project, teen fathers and expectant fathers receive parallel services to the female clients including psychosocial counseling, and social and medical care referrals.

The age range of clients is also consistent with project efforts at reaching high risk adolescents below the age of 17, with a majority (82 percent) of the clients between 15 and 17 years of age (an increase of eight percent from the 1982-1983 project year). A substantial number of clients (30 percent) are below the age of 15. New male clients were on the average older than the female clients (16.8 years compared with 15.9 for pregnant females; 17.1 years compared to 16.1 for entry parents).

As in previous years, many of TAPP's new clients are living with their parents (67 percent of expectant mothers and 71 percent of expectant fathers). Thus it appears important for TAPP to emphasize family involvement with the expectant teen and to provide counseling services for extended family members. Sixty-one percent of TAPP's pregnant clients and 57 percent of expectant fathers were still attending school at entry, but fewer parenting mothers were attending school (41 percent), as compared with 60 percent of fathers in the program (statistically significant $P<.05$).

Of clients leaving the program this year, 25 percent left with "self-sufficiency" status, that is they are capable of independently identifying and participating appropriately in social, educational, employment, and health services, as judged by program staff. This was a six percent increase from the previous program year (not statistically significant).

Other reasons clients leave the program include: 1) client's request to exit the program, 2) lack of eligibility for most clients when they reach the age of 18 and 3) lack of contact with program on an ongoing basis. In the latter case, case managers call, write, and make home visits in order to re-establish contact with their clients. It is only after multiple efforts at reaching the client have failed that the client is considered as exited from the program. In 1983-1984, 22 percent had moved away, while another 19 percent were lost to follow up, in spite of multiple efforts to reach them. Another 21 percent requested to leave the program. The TAPP staff needs to make a special effort to ascertain the underlying reasons for clients who leave the program in order to plan strategies to increase retention. For clients who continued the program participation, there have been increases in the lenght of time enrolled. Significantly more clients (46 percent as compared to 17 percent in the previous program year) continued in the program a minimum of one year. Thus, it appears that the TAPP program is increasing self-sufficiency and retention for both parenting and pregnant adolescents who remain active in the program.

II. Impact of the TAPP Project on Outcome Measures

A. Low birthweight births. Babies of birthweights less than 2500 grams (5.5 pounds) are known to be at highest risk of illness, disability and even death. Teens have higher rates of low birthweight births than women of other age groups. While low birthweight rates for all age mothers are around six percent in San Francisco, the low birthweight rate to teens not in a teenage pregnancy project was 14.1% in 1982. The low birthweight rate to pregnant teens in TAPP was 11.4% (1983-84). While this rate is lower than that for teens for San Francisco, it is of importance to determine what services within the TAPP program for pregnant mothers could lower the rate of low birthweight births.closer to that of the general population. Once there is a general understanding of what services are associated with lowest rates of low birthweight, these services can be directed preferentially to the pregnant teens. Improvements in birth outcomes can be expected especially if services associated with the lowest rate of low birthweights are directed to clients with the highest risk of having low birthweight babies.

TAPP provides direct and indirect services. Direct services are the TAPP's case management activities that include individual and group psychology sessions, nutrition counseling, childbirth, health and parenting education classes. Indirect services are referrals to public health nurses, doctors or clinics for prenatal care, food supplement programs (like WIC), Medi-Cal resources, cash grant support (AFDC) and other related services. We have investigated the associations of these services with low birthweight outcomes. While the number of clients available precluded multivariate analysis, we have controlled for other risk factors for low birthweight births. We have found particular services, both direct and indirect, associated with better rates of low birthweight births that could be focused on the high risk teens.

Whether pregnant TAPP clients received their prenatal health care at the Teen Clinics in the city at the General Hospital or Mount Zion Hospital or in regular private practice did not have any significant impact on low birthweight rates. Instead, what mattered was whether the pregnant teens were enrolled in a special high school for pregnant teens (a Pregnant Minor Program - PMP) or were school dropouts. Approximately half of the TAPP clients who gave birth in 1983-84 were enrolled in a Pregnant Minor Program, PMP (52 percent). The low birthweight rates for pregnant teens enrolled in the Pregnant Minor Program were lower (7.7 percent) than the rate for pregnant TAPP clients who were school dropouts during pregnancy (16.7 percent). This is true even though 29 percent of the enrollees in the Pregnant Minor Program were themselves school dropouts at the time they entered TAPP and, presumably, were at risk of a high low birthweight rate comparable to the other dropouts.

In the course of the evaluation, we investigated what could explain the lower rates of low birthweight births in the Pregnant Minor Program TAPP clients. We first examined whether the lower rates were because the participants in the Pregnant Minor Program were at lower risk of low birthweight births. Established risk factors for low birthweight births in general include inadequate prenatal care, being Black, being less than 18 years of age, not having been pregnant before, not having given birth before and being unmarried. Pregnant Minor Program TAPP clients had higher (and not lower) rates of all these risk factors than the school dropout TAPP clients, and yet, had fewer low birthweight births. Thus, it is not the absence of established risk factors for low birthweight births that explains fewer low birthweight births to Pregnant Minor Program participants.

In the course of the evaluation, two additional factors were found to be risks for low birthweight for the pregnant TAPP clients in general: (1) failure to enroll in a food supplement program (either WIC or another available federally sponsored program) and (2) living alone. Neither of these risk factors were significantly less prevalent among the Pregnant Minor Program participants and therefore, could not explain why they have lower rates of low birthweight.

What is likely to explain the better birthweight outcomes in the Pregnant Minor Program TAPP clients is the greater amount of TAPP direct services that they received through case management. TAPP clients who had dropped out of school received only 40 percent of the 15-minute units of service than were received by the clients in the Pregnant Minor Program. Thus, the Pregnant Minor Program participants received more group and individual psychology sessions, nutrition counseling and childbirth, health and parenting classes than the TAPP clients who were not in school. Further analysis is necessary to study the strength of the association between TAPP direct services and low birthweight rates and it is possible that additional factors play a role. But at present, TAPP case management direct services are related to improved health outcomes of the babies of the teens at birth.

The findings of the low birthweight outcome evaluation generally indicate that the greatest opportunities to reduce low birthweight rates is among school dropouts who enroll in TAPP. Improvements in the low birthweight rates of the TAPP clients are to be expected if teens leaving school while pregnant would enroll in the Pregnant Minor Program High School. This would be particulary true for the Black clients, since the low birthweight rate for Black teen dropouts was 31.6 percent, while the rate for Black teens in the Pregnant Minor Program was significantly lower (11.3 percent). Nearly a quarter (24 percent) of those teens who were dropouts during pregnancy had been enrolled in school at the time of entry to TAPP and would be a primary group to target for Pregnant Minor Program participation. If enrollment of the teen is impossible, then intensified efforts to increase case management direct services for school dropout clients should be associated with improved low birthweight rates.

Additional opportunities to improve low birthweight rates, even for Pregnant Minor Program clients, were also documented in this evaluation. Prenatal care and food program enrollment were shown to be associated with improved low birthweight rates. TAPP clients with ten or more prenatal care visits and participation in food supplement programs (such as WIC) had lower rates of low birhtweight births. For Pregnant Minor Program participants, some 40 percent had not had at least ten prenatal care visits and only 19 percent enrolled in food programs. Thus, further improvements in low birthweight rates could reasonably be expected if prenatal care visits and food program participation were increased in Pregnant Minor Program clients.

There were too few pregnant TAPP clients who attended schools other than the Pregnant Minor Programs to detect low birthweight rates significantly different from either the Pregnant Minor Program clients or the school dropout clients. Their low birthweight rate was between that of the other two groups (11.5 percent). These clients received units of service at 40 percent the level of Pregnant Minors Program clients, not different from those of the school dropout clients. Further analysis of an increased number of pregnant TAPP clients attending other high schools is necessary to establish whether their low birthweight rates are indeed higher than the Pregnant Minor Program clients as is expected from the association of TAPP units of direct services with lower rates of low birthweight births.

B. School Continuation, Women who become mothers while still adolescents have reduced educational and occupational attainment, lower incomes, and increased welfare dependency. Pregnancy is the most commonly reported reason for dropping out of school among females in the United States. An average of 42 percent of the clients enrolled in TAPP funded projects aimed at assisting pregnant adolescents are high school dropouts. Because of the program's goal to improve school continuation of pregnant teens, we have begun to investigate changes in school status as TAPP female clients progressed through pregnancy and the postpartum period. The changes were investigated to identify the association of school status in TAPP during pregnancy with school continuation after birth. It is of interest to know which TAPP clients are at risk of dropping out of school and what impact various TAPP services have on reducing the prevalence of school dropouts.

Significantly more female clients who were not enrolled in school at entry to TAPP attended school during pregnancy than remained dropouts. The availability of a Pregnant Minor Program to TAPP clients appears to increase the chances that a school dropout will return to school while pregnant: nearly four times as many of the clients who had already dropped out of school by the time they enter TAPP, enrolled in the Pregnant Minor Program as compared to those teens enrolled in regular city schools. Even pregnant female clients who were enrolled in a school at the time of entry to TAPP elected to transfer to the Pregnant Minor Program nearly three times as often as remain in their old school or transfer to another city school.

Pregnant Minor Program clients, however, must leave their special school at the end of the semester in which their babies are born. The findings of the evaluation indicate that the dropout rate seven months after the babies are born to Pregnant Minor Program participants, though low (27 percent) is not different than it had been for those clients at entry to TAPP (23 percent). Thus, although schooling has been extended for these clients, a larger proportion of the clients would be likely to reach graduation if they could continue in the Pregnant Minor Program after the birth of their babies. In an earlier client satisfaction survey, several aspects of the Pregnant Minor Program were found to be particularly helpful for those clients who had previously dropped out of school: smaller classes, individualized teaching, and group support. It may thus be important to consider the potential advantages of allowing clients to continue in the Pregnant Minor Program after the semester of birth of the babies.

Female clients who remain in other city schools during pregnancy have the lowest rates of discontinuing school enrollment both seven (10 percent) and 12 months (one percent) after the babies are born when compared with PMP or dropout female clients. While the number of clients successfully followed in this group is far too small to be conclusive, it appears that these clients are most successful at school continuation, which may reflect motivations independent of TAPP intervention. Further analysis of larger numbers of these clients by units of TAPP direct services after birth is necessary to investigate the association of TAPP services with the school continuation of this group.

The school dropout rate seven months after birth for female clents who had been dropouts during pregnancy are higher (47 percent) than those for clients who had been in the Pregnant Minor Program or in other schools during pregnancy (10 to 23 percent). However, the rates are lower than they had been at entry to TAPP (69 percent). Thus, some teens not in school during pregnancy do return to school after birth. However, one year after birth, the dropout rates for those not in school during pregnancy are as high as they had been at entry to TAPP (69 percent).

Thus, while school participation is extended for many TAPP clients because of their involvement in TAPP and its associated Pregnant Minor Programs, much could be done to improve graduation rates. Further analysis of whether the units of TAPP services given after birth are associated with higher school continuation rates requires larger numbers of teens to be followed after birth. Intensified followup, even it only for outcome data on as many exited clients as possible, might prove useful in future evaluations. It would then also be possible to identify various risk factors for dropping out of school in these clients both before and after the babies are born.

C. Repeat Birth Rates Demographic studies of pregnant and parenting adolescents have shown that many of these teens experience second or third pregnancies. For example, of the 570,609 births to teenagers in 1977, over one fourth were a second or higher order births (National Center for Health Statistics, 1979). For the young mothers themselves, higher order births are associated with serious negative consequences. In terms of educational impact, each successive pregnancy increases the likelihood of dropping out of school (Furstenberg, 1976). Higher order births have a similiar impact on employment. Furstenberg reported that five years after an index pregnancy, 43 percent of the teen mothers with one child were employed, compared to 10 percent of the multiparous women.

Various studies have placed the repeat pregnancy rate for adolescents within a two-year period as ranging from 60 to 80 percent. The repeat rates for TAPP clients one and two years postpartum, 2 and 10 percent respectively are very low. As previously discussed, TAPP's emphasis on school continuation, as well as direct assistance with navigating the social and health care systems appears to contribute to this low repeat birth rate. Ideally, an evaluation of those who drop out of TAPP could be conducted in order to fully assess the repeat birth rates for those who chose to discontinue program participation, thus providing us with a more complete picture of the program impact.

III. Case Manager's Survey

In an effort to gain insights into the context of program practice, an in-depth survey of TAPP staff was conducted to define the roles and functions of case managers working with pregnant and parenting adolescents. Case managers or continuous counselors are identified as important program links in the following ways:

1) identifying and conducting outreach;
2) identifying appropriate services to meet client needs;
3) providing ongoing counseling; and
4) assisting the clients in selecting the most appropriate service providers.

Staff were asked closed and open ended questions on a variety of related topics, including work characteristics, types of tasks and responsibilities, relationships to both male and female clients, parental involvement, service broker and counselor roles, personal qualities and problems faced in implementing the case management role.

Case managers see themselves as able to provide a combination of "service broker" and "counselor" roles to their clients. A skilled case manager is one who knows how to identify the most appropriate services for his/her clients and who "builds" on client's strengths as a means of teaching the process of "self-sufficiency". Among the most important qualities ranked by the case managers as contributing to a successful professional are life/professional experiences, education, knowledge/skills and personal qualities. Counseling and communication skills, as well as knowledge of adolescents and community resources, are also important. The majority of the staff members(62 percent) expressed that providing personal counseling was the most important aspect of their role, although matching client needs and available resources, as well as following up on their referrals were also of importance.

When asked to compare their roles to other social service providers, 70 percent of the group identified the case-manager's uniqueness as their capacity to provide a wide range of services over an extended period of time. The time element thus enables the case manager to provide a continuously changing set of services as their clients' needs evolve. One staff manager eloquently expressed the concept of case managers, as that of being a "semi-permanent guiding reference for a client, assisting in all life skill areas - like being a North Star."

The most important problem identified by the case managers in completing their role was having inadequate time to implement all aspects of their role. Thus a heavy case load conflicts with their ability to provide all the comprehensive services for which they are responsible. The case managers recommended that case loads need to be limited at approximately 30 in order to provide intensive counseling, follow up, and other related services.

It may be imperative for adolescent pregnancy programs providing case management to triage clients in terms of need (e.g. assessing which clients are in greatest need of intensive counseling) as compared to "monitoring" activities, assuming that clients do receive services which they need. There may also be a need to match case manager skills with client needs. Thus, matching counselors who desire to provide more clinical counseling with clients in greater need of this intensive care, and matching case managers who provide counseling, but wish to emphasize the social agency "broker" role with clients in greater need of broker services should potentially be considered in program planning. The case managers recommend that there be on-going supervision by clinical psychologists, particularly in complex cases. There is also a need to develop time flexibility in performing various aspects of the case manager's role.

The role of case manager appears to play a major role in the positive impact of the TAPP project. The case manager appears to be a valuable resource for clients and their communities. They assure that available resources are used efficiently, avoiding the misuse and duplication of services. But most importantly, they have a positive impact on their client's lives.

CLIENT DEMOGRAPHICS AT ENTRY - 1983-1984

Part 1

COMPARISON WITH EARLIER YEARS OF THE TAPP PROJECT

PROBLEM STATEMENT

The Teenage Pregnancy and Parenting Project (TAPP) project was developed to provide care and network services to an areawide population of pregnant and parenting adolescents, their infants, fathers or partners, and extended family members. A priority in services was given to those 17 years of age and under. The overall goal of the project is the reduction of unintended pregnancies, and the provision and advocacy for needed comprehensive health, social, educational and infant services.

In accordance with the Office of Adolescent Pregnancy Program's mandate to focus its efforts on high-need, underserviced areas, TAPP has aimed at reaching all adolescents in need of services, within San Francisco, with a special focus on those clients residing in geographic areas which have limited or no existing services aimed at pregnant or parenting adolescents.

Economic conditions in San Francisco vary greatly and there is wide disparity within the city in terms of personal economics. Of San Francisco's total population, approximately 14% live below poverty level, although in several of TAPP's target areas the poverty level is as high as 30% of the total population. San Francisco has one of the most diverse ethnic populations in the United States. Within the primary target areas of the TAPP project Black and Hispanic populations are in the majority. In the initial application to the Office of Adolescent Pregnancy Programs, TAPP reported that among adolescents, 17 years of age and under, delivering their first child in San Francisco, that 52% were Black, 38% were White/Hispanic, 5% were Filipino and 5% other ethnic and racial groups.

The TAPP target areas contain the largest proportion of the least educated groups. These areas also encompass the largest proportion of unskilled and semi-skilled workers and the smallest proportion of professional and managerial workers. Unemployment rates in the TAPP target areas are among the highest in the city.

The San Francisco Department of Social Services (DSS)(responsible for determining eligibility and providing support for public assistance programs, including AFDC, Medi-Cal, and Food Stamps) reports that 40% of all adolescent parents are dependent on public assistance. Consistent with national figures, school dropout rates for the pregnant adolescent in San Francisco has been shown to be approximately 80% (Williams, 1982). Lack of adequate child care and access to other support services has often acted as a barrier in the young mother's effort to return to her school. Additionally national studies indicate that in the absence of prevention programs, adolescents who give birth often become pregnant again within a short time - - 44% within one year and 70% within two years (Mecklenberg, 1983).

INTERVENTION STRATEGIES

This brief description of San Francisco's pregnant and parenting adolescents before the beginning of the TAPP project delineates that the provision for and access to specialized services for adolescents was minimal. The first section of this evaluation assesses the ability of the TAPP program to maintain its ability to target and reach high-risk adolescents. The effectiveness of the project's outreach efforts at enrolling high-risk pregnant and parenting adolescents has been evaluated by analyzing the demographic profile of entry clients for 1983-1984. An initial assessment of the program's ability to retain clients has been evaluated by analyzing exit data for program clients.

EVALUATION

This evaluation assesses the TAPP project's efforts at meeting each of the following objectives.

Goal: To improve pregnancy outcomes and social consequences of unintended pregnancy by providing comprehensive health education and social services, for high risk adolescents age 17 and under.

Objectives:

A. To provide outreach and to enroll a minimum of 225 new high-risk pregnant and parenting adolescents in a comprehensive service program. High risk is defined as being below the age of 17, low income, a member of an ethnic minority and/or a school dropout. Associated risk factors have been identified as unemployed and/or on probation or court dependent.

B. To retain a minimum of 275 high-risk clients in the TAPP project for a minimum of six months with special emphasis on providing care for the pregnant adolescent.

C. To increase by 10% the proportion of clients who leave the TAPP project once they have become self-sufficient, capable of continuing school or employment without programmatic support from a case manager.

The working hypothesis for this section of the evaluation is that an extensive outreach effort as part of a community-wide, comprehensive service for pregnant and parenting adolescents can have a positive effect in identifying, enrolling and retaining high risk youth.

2. Instrumentation and Analysis

Examples of the entry and exit data forms used in the project are included in Appendix I. For Part 1 of the evaluation, the analysis consisted of comparing a baseline demographic profile of TAPP clients entering the program in 1983-1984, to those clients entering in the project's first two years. Where change occured in demographic variable, a chi-square statistical analysis was conducted to assess whether these changes were statistically significant. The following section summarizes the demographic profiles of clients enrolled in the TAPP project for 1983-1984.

Entry Status

In its third year, TAPP exceeded its goal, enrolling a total of 271 new clients. Thus a total of 837 clients have received services since the program's inception in October, 1981 (Table 1). As in former years, nearly two-thirds of new clients were pregnant teens at entry. The proportion of clients who are already mothers at time of program entry has declined significantly, from 30% in 1981-1982 to about 15% in 1982-1984 ($P \text{ Value} < .05$). The Fatherhood Project, in operation since 1983, has grown to the extent that young fathers and expectant fathers (formerly 6% of TAPP clients) are now nearly 20 percent of clients. The remaining TAPP clients (2%) are individuals who while not pregnant are considered to be at high risk of pregnancy and needing TAPP services.

Age of Clients

The majority of new female clients were between the ages of 15-17 with a range of ages from 12 to 19, (94 percent of pregnant clients and 95 percent or entry mothers, Table 2); Thirty percent of female clients were 15 or younger, three percent were 18 or older at entry. Consistently for the past two years, three-fourths of female clients are 16 or 17.

New male clients were on the average significantly older than the female clients (16.8 years for expectant fathers compared with 15.9 for expectant mothers and 17.1 years as compared to 16.1 years for entry parents). Thirty-six percent of fathers or fathers-to-be were 18 or older. This is true despite the special focus of the Fatherhood Project on young males under the age of 18 which puts limitations on the type of outreach and involvement of males who are 18 or over. While the older male client may be involved as part of the TAPP client's program enrollment, he may not qualify for the full range of services the younger male will receive, whether or not his partner is involved in the program. Giving priority to the younger male may be warranted since this age group is likely to be in even greater need of the specialized programs available through TAPP.

TABLE 1. STATISTICAL PROFILE OF NEW CLIENTS ENROLLED THROUGH SEPTEMBER 30, 1984

ENTRY STATUS	1983-84 Number and Percent	1982-83 Number and Percent	1981-82 Number and Percent
FEMALES			
PREGNANT TEEN	180 (60%)	208 (65%)	153 (63%)
ENTRY MOTHER ▲	37 (14%)	47 (15%)	73 (30%)
OTHER FEMALE*	1 (1%)	1 (-)	4 (2%)
MALES			
EXPECTANT FATHER	35 (13%)	39 (12%)	
ENTRY FATHER	15 (6%)	24 (7%)	14 (6%)
OTHER MALE*▲▲	1 (-)	3 (1%)	
TOTAL	271 (100%)	322 (100%)	244 (100%)

---

*Other types of females and males include individuals who received counseling and referral services.

** Not applicable.

▲ P Value of decline 1981-1982, compared with 1982-1983 = $P < .05$
P Value of decline 1981-1982, compared with 1983-1984 = $P < .05$

▲▲ P Value of rise 1981-1982, compared with 1982-1983 = $P < .05$
P Value of rise 1981-1982, compared with 1983-1984 = $P < .05$

TABLE 2 AGE BY ENTRY STATUS OF NEW CLIENTS, 1982-83 and 1983-84

ENTRY STATUS	12	13	14	15	16	17	18	18+	Mean Age*
Females									
Pregnant									
1982-83	1	2	16	32	61	86	10	-	16.2
1983-84	2	4	16	33	58	61	6	-	15.9
Entry Mother									
1982-83	-	1	3	7	17	16	3	-	16.1
1983-84	-	1	1	9	10	16	-	-	16.1
Total Female									
1982-83	1	3	19	39	79	102	13	-	16.1
1983-84	2	5	17	42	69	78	6	1	16.3
Males									
Expectant Father									
1982-83	-	-	-	2	3	6	6	22	17.5
1983-84	-	-	1	3	9	11	4	7	16.8
Entry Father									
1982-83	-	-	-	3	2	2	7	10	17.4
1983-84	-	-	1	-	3	4	4	3	17.1
Other Male									
1982-83	-	-	-	-	-	-	1	2	18+
1983-84	-	-	-	-	-	1	-	-	16
Total Males									
1982-83	-	-	-	5	5	8	14	34	17.6
1983-84	-	-	-	3	12	16	8	10	16.6
TOTALS AND PERCENTAGES									
1982-83	1 (1%)	3 (1%)	19 (6%)	44 (14%)	84 (26%)	110 (34%)	27 (8%)	34 (11%)	322 100%
1983-84	2 (1%)	5 (2%)	19 (7%)	45 (17%)	81 (30%)	94 (35%)	14 (5%)	11 (4%)	271 100

---

* Assuming those over 18 are 19 or 20 years of age.

However, it should be recognized that in general the males tend to be older and may have different age-dependent needs and outcomes.

Table 2 illustrates that the TAPP program, in general, is focusing on reaching and providing care for younger clients. There were small increases in younger clients (from 8 to 10 percent aged 14 and below), and an increase in the number of clients who were 15 to 17 (from the 74 percent to 82 percent).

Ethnicity and Language

As in the original proposal to the office of Adolescent Pregnancy Programs, TAPP continues to be consistent in meeting the needs of high risk adolescent mothers and pregnant adolescents living in San Francisco County, many of whom represent ethnic minorities.

As shown in Table 3, 78 percent of new program clients in 1983-84 were Black (47 percent) or Hispanic (31 percent). This figure is consistent with previous years (77 percent in 1982-83 and 75 percent in 1981-82). Other ethnic groups represented within the TAPP caseload were White, non-Hispanic (7%), Filipino (7%), American Indian (2%), Chinese (1%), and Southeast Asian (3%).

Language

The number of clients whose primary language is English increased from 64 to 70 percent in this year's program (not statistically significant at $P<05$). Sixteen percent of the clients spoke both English and Spanish, while six percent only spoke Spanish. Other languages spoken by TAPP clients include Cantonese and Southeast Asian languages. While Southeast Asian clients are still in a minority, TAPP has enlisted the assistance of translators who speak different Southeast Asian languages to work as case manager aids in several instances. This capacity to respond linguistically and culturally to the changing demographic patterns of potential TAPP clients is a particular strength of the TAPP program.

TABLE 3 ETHNIC DISTRIBUTION BY ENTRY STATUS 1982-1983 and 1983-1984

Status	Black	Hisp. White	White Not Hisp.	Filipino	Amer. Indian	Chinese	Japanese	South East Asian	Other	Total
Pregnant										
1982-1983	99	60	21	13	4	1	-	5	5	208
1983-1984	85	57	14	11	3	1	-	6	3	180
Entry Mother										
1982-1983	25	13	2	4	-	-	-	1	2	47
1983-1984	21	7	2	2	2	2	-	1		37
Other Female Teen										
1982-1983	-	1	-	-	-	-	-	-	-	1
1983-1984	2	-	-	-	-	1	-	-	-	3
Expectant Father										
1982-1983	13	12	4	6	-	1	-	2	1	39
1983-1984	10	14	3	5	1	-	-	1	1	35
Entry Father										
1982-1983	14	7	-	1	-	-	-	1	1	24
1983-1984	9	5	-	1	-	-	-	-	-	15
Other Male										
1982-1983	-	3	-	-	-	-	-	-	-	3
1983-1984	-	1	-	-	-	-	-	-	-	1
TOTAL										
1982-1983	151 (47%)	96 (30%)	27 (8%)	24 (7%)	4 (1%)	2 (1%)	0 (0%)	9 (3%)	9 (3%)	322 (100%)
1983-1984	127 (47%)	84 (31%)	19 (7%)	19 (7%)	6 (2%)	4 (1%)	- -	8 (3%)	4 (1%)	271 (99%)

TABLE 4

LANGUAGE SPOKEN BY ENTRY STATUS 1982-1983 and 1983-1984

	English	English and Spanish	Spanish	Other	Total
PREGNANT					
1982-1983	139	38	14	17	208
1983-1984	125	31	12	12	180
ENTRY MOTHER					
1982-1983	30	7	5	5	47
1983-1984	27	3	2	5	37
OTHER FEMALE TEEN					
1982-1983	1	-	-	-	1
1983-1984	2	-	-	1	3
EXPECTANT FATHER					
1982-1983	20	8	3	8	39
1983-1984	26	4	2	3	35
ENTRY FATHER					
1982-1983	16	6	-	2	24
1983-1984	10	4	1	-	15
OTHER MALE					
1982-1983	-	3	-	-	3
1983-1984	1	-	-	-	1
TOTAL					
1982-1983	206 (64%)	62 (19%)	22 (7%)	32 (10%)	322 (100%)
1983-1984	191 (70%)	42 (16%)	17 (6%)	21 (8%)	271 (100%)

Marital Status and Living Arrangements

There was a slight decrease in the number of clients who were married when they entered the program. As shown in Table 5, seven percent of clients were married, as compared to 10 percent during 1982-83 (statistically not significant). Consistent with the findings of last year and with national studies most program clients (64 percent) were dependent on their parents for their living arrangements.

As shown in Table 6, there was a slight but significant decrease in the number of clients living with their spouses or with other partners, with 14 percent of teens in 1983-84 living with partners as compared to 10 percent of clients in the previous year. Simultaneously there was an increase (from 19 percent in 1982-83 to 22 percent in 1983-84) in the number of clients living with people other than their parents or a spouse, including extended family members. Since 67 percent of expectant mothers and 71 percent of expectant fathers were living with their parents, it appears particularly crucial for TAPP to have included family counseling as an important service.

Previous Pregnancies

Of the clients enrolled in TAPP, almost 20 percent had had one or more previous pregnancies (Table 7). Of this group 90% (17 percent of the total) had had one previous pregnancy, while 10 had had two pregnancies and one client had experienced three pregnancies. However, the majority (81%) of clients were facing their first pregnancy when they became TAPP clients. No significant changes occurred in the proportions of clients with one or more previous pregnancies when 1983-84 is compared with previous years.

TABLE 5

MARITAL STATUS BY ENTRY STATUS
1982-1983 and 1983-1984

	Single	Married	Divorced	Separated	Total
PREGNANT					
1982-1983	188	19	-	1	208
1983-1984	165	15	-	-	180
ENTRY MOTHER					
1982-1983	40	5	-	2	47
1983-1984	35	2	-	-	37
OTHER FEMALE TEEN					
1982-1983	1	-	-	-	1
1983-1984	3	-	-	-	3
EXPECTANT FATHER					
1982-1983	33	5	-	1	39
1983-1984	33	2	-	-	35
ENTRY FATHER					
1982-1983	22	2	-	-	24
1983-1984	14	1	-	-	15
OTHER MALE					
1982-1983	2	-	1	-	3
1983-1984	1	-	-	-	1
TOTAL					
1982-1983	286 (89%)	31 (10%)	1 (<1%)	4 (<1%)	322 (100%)
1983-1984	251 (93%)	20 (7%)	- -	- -	271 (100%)

TABLE 6

LIVING ARRANGEMENTS BY ENTRY STATUS
1982-1983 and 1983-1984

	Parents	Spouse	Other Partner	Alone	Other	Total
PREGNANT						
1982-1983	138	13	18	3	36	208
1983-1984	120	11	14	2	33	180
ENTRY MOTHER						
1982-1983	25	4	4	1	13	47
1983-1984	21	1	3	-	12	37
OTHER FEMALE TEEN						
1982-1983	1	-	-	-	-	1
1983-1984	1	-	-	-	2	3
EXPECTANT FATHER						
1982-1983	21	4	7	2	5	39
1983-1984	25	1	1	-	8	35
ENTRY FATHER						
1982-1983	12	-	3	2	7	24
1983-1984	6	-	6	-	3	15
OTHER MALE						
1982-1983	1	-	2	-	-	3
1983-1984	-	-	-	-	1	1
TOTAL						
1982-1983	198 (61%)	21 (7%)	34 (11%)	8 (2%)	61 (19%)	322 (100%)
1983-1984	173 (64%)	13 (5%)	24 (9%)	2 (<1%)	59 (22%)	271 (100%)

TABLE 7

NUMBER OF PREVIOUS PREGNANCIES BY ENTRY STATUS 1982-1983 and 1983-1984

	None	One	Two	Three or More	Unknown	Total
PREGNANT						
1982-1983	160	39	8	1	-	208
1983-1984	141	34	4	1	-	180
ENTRY MOTHER						
1982-1983	42	3	2	-	-	47
1983-1984	34	3	-	-	-	37
OTHER FEMALE TEEN						
1982-1983	1	-	-	-	-	1
1983-1984	2	1	-	-	-	3
EXPECTANT FATHER						
1982-1983	31	6	1	-	1	39
1983-1984	32	2	1	-	-	35
ENTRY FATHER						
1982-1983	23	1	-	-	-	24
1983-1984	11	4	-	-	-	15
OTHER MALE						
1982-1983	2	1	-	-	-	3
1983-1984	-	1	-	-	-	1
TOTAL						
1982-1983	259 (80%)	50 (16%)	11 (3%)	1 (1%)	1 (1%)	322 (100%)
1983-1984	220 (81%)	45 (17%)	5 (2%)	1 (<1%)	- (<1%)	271 (100%)

School Enrollment at Entry

This year's TAPP new clients had a five percent increase in the number of participating clients who had either graduated or were still attending school (from 54 percent in 1982-83 to 59 percent in 1983-84) (not statistically significant at $P < .05$). For female clients, there was an increase (though not statistically significant at $P < .05$) in the percentage of pregnant adolescents enrolled in school (from 55 percent to 61 percent), from 1982-1983 to 1983-1984, while the number of entry mothers enrolled in school in 1983-1984 was significantly lower (4%).

For male clients, 57 percent of expectant fathers and 67 percent of entry fathers were either enrolled or had graduated from school. There were statistically higher levels of school enrollment for expectant fathers than for pregnant mothers (49 percent males and 61 percent females). There was also a disparity (significant $P < .05$) between entry mothers and entry fathers in terms of school status (41 percent for females, in contrast to 60 percent for fathers). This latter finding may be another indicator of the differential difficulty young women face in completing school once their child is born and may also reflect the age differential between males and females enrolled in the program.

Forty-eight percent of clients entering the program in 1983-84 had been out of school less than six months and another 24 percent left school in the previous six to 12 months (Table 9). The TAPP staff has decreased the proportion of clients with unknown lengths of time out of school dramatically (from 20 percent to three percent of clients). Of those with known time periods out of school, there has not been a significant change in the distribution of lengths of time the clients are out of school.

TABLE 8. SCHOOL ENROLLMENT BY ENTRY STATUS, 1982-83 and 1983-84

	Attending	Dropped Out	Graduated	Unknown	Total
PREGNANT					
1982-83	114	87	5	2	208
1983-84	110	67	3		180
ENTRY MOTHER					
1982-83	18	27	2	-	47
1983-84	15	22			37
OTHER FEMALE TEEN					
1982-83	1	-	-	-	1
1983-84	1	1	1		3
EXPECTANT FATHER					
1982-83	12	16	11	-	39
1983-84	17	15	3		35
ENTRY FATHER					
1982-83	7	15	2	-	24
1983-84	9	5	1		15
OTHER MALE					
1982-83	2	1	-	-	3
1983-84	-	-	1		
TOTAL					
1982-83	154	146	20	2	322
(%)	(48%)	(45%)	(6%)	(1%)	(100%)
1983-84	152	110	9		271
(%)	(56%)	(41%)	(3%)		(100%)

TABLE 9. LENGTH OF TIME DROPPED OUT OF SCHOOL, BY AGE, ENTRY CLIENTS, 1982-83 AND 1983-84

Time Dropped Out	AGE						
	<14	14	15	16	17	18+	Total
<6 MONTHS							
1982-83	1	6	7	26	20	7	67 (46%)
1983-84	1	4	10	17	17	2	51 (46%)
6 MOS. - 1 YR.							
1982-83	-	-	3	3	9	5	20 (14%)
1983-84	-	-	3	6	11	6	26 (23%)
1 YR. - 2 YRS.							
1982-83	-	-	-	6	8	3	17 (12%)
1983-84	-	2	1	5	6	1	15 (14%)
2 YRS.+							
1982-83	-	-	1	-	3	9	13 ([illegible])
1983-84	1	1	1	2	6	4	15 (14%)
UNKNOWN							
1982-83	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1983-84	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
TOTAL							
1982-83	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
(%)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1983-84	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
(%)	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Overall, there was a four percent increase (from 39% in 1982-1983 to 43% in 1983-1984) in the total number of school dropouts among clients entering [illegible] (see Table [illegible]). The majority of school dropouts were either 16 to 17 years of age (69%).

Table 9A summarizes the length of time dropped out of school for the two largest categories of clients: pregnant teens and entry mothers. There was an increase this year in the number of new clients who had been out of school at least six months and less than one year. For pregnant adolescents, there was an increase from 13 percent (1982-1983) to 23 percent (1983-1984), (not statistically significant at $P < .05$); while for entry mothers, there was an increase from 18 percent to 27 percent (not statistically significant at $P < .05$). It is difficult to assess whether these changes are significant differences within the new client population, or whether it reflects a greater effort at documenting dropout status by TAPP counselors during calendar year, 1983-1984.

TABLE 9A. LENGTH OF TIME DROPPED OUT OF SCHOOL, BY AGE, FOR PREGNANT AND ENTRY MOTHER CLIENTS, 1982-83 AND 1983-84

	PREGNANT							ENTRY MOTHER						
	<14	14	15	16	17	18	Total	<14	14	15	16	17	18	Total
[illegible]														
1982-83	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1983-84	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
6 MOS. - 1 YR.														
1982-83	-	-	2	1	6	-	9 (10%)	-	-	-	2	2	-	4 (15%)
1983-84	-	-	1	4	7	3	15 (22%)	-	-	2	1	3	-	6 (27%)
1 YR. - 2 YRS.														
1982-83	-	-	-	5	6	-	11 (13%)	-	-	-	1	1	-	2 (7%)
1983-84	-	2	1	2	4	-	9 (14%)	-	-	-	3	2	-	5 (23%)
2 YRS.+														
1982-83	-	-	-	-	1	1	2 (2%)	-	-	1	-	2	-	3 (11%)
1983-84	1	1	1	1	2	-	6 (9%)	-	-	-	1	3	-	4 (18%)
UNKNOWN														
1982-83	-	1	4	4	7	-	16 (18%)	-	-	1	-	3	1	5 (19%)
1983-84	-	-	1	-	1	-	2 (3%)	-	-	-	-	-	-	-
TOTAL														
1982-83	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]
1983-84	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

Employment and Welfare Status

Given the age of TAPP clients it is not surprising that a majority of the TAPP clients under the age of 18 are unemployed ([illegible] percent). In the case of [illegible] expectant fathers, [illegible] employment figures for both males and females reflect the fact that many are still attending school.

The proportion of clients receiving public assistance at entry to TAPP was 38 percent (Table 11). Twenty-three percent were receiving Aid to Families with Dependent Children (AFDC), 21 percent received AFDC along with Medi-Cal and 15 percent received Medi-Cal only. There was a decrease from 45 percent (1982-1983) to 39 percent (1983-1984) in the number of pregnant adolescents receiving welfare support, while the number of entry mothers in these special assistance programs remained consistent at 54 percent. Of those females receiving AFDC, the majority were within their family's grant ("in grant" status) and were not receiving funds directly themselves ("payee" status). This finding was consistent with that of males, although their small number prevents this report to include a profile of teen fathers on welfare.

TABLE 10

EMPLOYMENT BY ENTRY STATUS
1982-1983 and 1983-1984

	Pregnant	Entry Mother	Other F. Teen	Expectant Father	Entry Father	Other Male	Total
EMPLOYED							
1982-1983	19	2	-	17	8	1	47 (15%)
1983-1984	17	2	2	10	2	1	34 (13%)
UNEMPLOYED							
1982-1983	188	45	1	22	16	2	274 (85%)
1983-1984	162	35	1	24	13	-	235 (87%)
UNKNOWN							
1982-1983	1	-	-	-	-	-	1 (1%)
1983-1984	1	-	-	1	-	-	2 (1%)
TOTAL							
1982-1983	208	47	1	39	24	3	322 (100%)
1983-1984	180	37	3	35	15	1	271 (100%)

TABLE 11

WELFARE STATUS BY ENTRY STATUS
1982-1983 and 1983-1984

	Pregnant	Entry Mother	Other F. Teen	Expectant Father	Entry Father	Other Male	Total
	(n=208)	(n=47)	(n=1)	(n=39)	(n=24)	(n=3)	(n=322)
	(n=180)	(n=37)	(n=3)	(n=35)	(n=15)	(n=1)	(n=271)
Medi-Cal Only							
1982-1983	31	1	-	2	2	-	36 (11%)
1983-1984	24	9	1	5	1	-	40 (15%)
Medi-Cal & AFDC							
1982-1983	58	22	1	3	1	-	85 (26%)
1983-1984	43	11	-	4	-	-	58 (21%)
AFDC/Payee							
1982-1983	11	6	-	-	-	-	17 (5%)
1983-1984	5	5	-	1	-	-	11 (4%)
AFDC/in grant							
1982-1983	45	12	1	3	3	-	64 (20%)
1983-1984	36	4	-	3	-	-	43 (16%)
Total AFDC							
1982-1983	62	24	1	3	3	-	93 (29%)
1983-1984	47	11	1	4	-	-	63 (23%)
Total Receiving Welfare ("AFDC" & Medi-Cal only							
1982-1983	93	25	1	5	5	-	129 (40%)
1983-1984	71	20	2	9	1	-	103 (38%)
Percent of Total Number in Entry Status							
1982-1983	45%	53%	100%	13%	21%	-	322 (100%)
1983-1984	39%	54%	67%	26%	7%		271 (100%)

Court Dependency/Probation Status

As in 1982-1983, Table 12 shows that the vast majority of TAPP clients had no dependency/probationary status (87 percent). Five percent or less had either "601" status (runaways or truants), "602" status (criminal convictions), or "300" status (dependents of the court). The dependency status for three percent of this group was unknown. It is difficult to study parenting and pregnant adolescents living in San Francisco who are not enrolled in the TAPP project in order to assess whether they have a similar or different incidence of dependency/probation status. While TAPP case managers do provide outreach services to high risk clients, adolescents who have dependency/probation related problems may be unable to maintain an ongoing relationship as emphasized by TAPP. Consequently, we are unable to evaluate how effective TAPP has been at providing services to clients with these law related problems.

TABLE 12

DEPENDENCY/PROBATION STATUS BY ENTRY STATUS
1982-1983 and 1983-1984

	Pregnant	Entry Mother	Other F. Teen	Expectant Father	Entry Father	Other Male	Total
300							
1982-1983	5	-	-	1	-	-	6 (2%)
1983-1984	2	-	-	1	-	-	3 (1%)
601							
1982-1983	8	4	-	1	3	-	16 (5%)
1983-1984	9	2	-	1	3	-	13 (5%)
602							
1982-1983	7	1	-	2	3	-	13 (4%)
1983-1984	4	-	-	7	1	-	12 (4%)
Adult Prob.							
1982-1983	-	-	-	1	1	-	2 (< 1%)
1983-1984	-	-	-	-	1	-	1 (< 1%)
Unknown							
1982-1983	3	2	-	-	-	-	5 (2%)
1983-1984	5	1	-	1	-	-	7 (3%)
None							
1982-1983	185	40	1	34	17	3	280 (87%)
1983-1984	160	34	3	25	12	1	235 (87%)
Total							
1982-1983	208	47	1	39	24	3	322 (100%)
1983-1984	180	37	3	35	15	1	271 (100%)

Reasons for Referrad to TAPP

Approximately one third of the 271 new clients for 1983-84 were referred by hospitals, clinics and physicians (Table 13). This represents an 11 percent decrease from the 1982-1983 program data (staistically significant at $P < .05$). However, a statistically significant ($P < .05$) increase in the proportion of clients' friends (from 21 percent in 1982-83 to 25 percent in 1983-84) and schools (from 13 percent to 20 percent) as primary sources for referral was documented. Social service agencies as well as the Department of Social Services were also an important source of referral as 16 percent of clients first learned about TAPP from those agencies, this data documents change in the character of referral patterns, with increased acceptance and recognition of the TAPP project in the wider community. This number parallels the 17 percent of clients referred to the program in the previous year by these agencies.

Pregnant teens were referred primarily by hospitals, clinics and physicians (48 percent), schools (17 percent) and social service agencies (16 percent), Table 13A. Comparatively, entry mothers were referred less often by hospitals, clinics and physicians (38 percent) and more often by social services (38 percent) than pregnant clients, (Table 13B). This finding may reflect the fact that a large proportion of entry mothers are not attending school (69 percent of entry mothers, as compared to 39 percent of pregnant teens) and, are thereby only referred to TAPP through the social services network. Additionally, high schools may have more difficulties in identifying high school students who already have children than those who are pregnant. Pregnant adolescents may also be more easily identified by all referral sources, thus, increasing the probability of entry into a comprehensive program. Friends or family members were the major source of referral for expectant fathers (57 percent) and for entry fathers (47 percent). About 20 percent of expectant fathers were referred to the program by a health clinic or hospital, (Table 13C).

TABLE 13. REFERRING AGENCIES OR SOURCES FOR ENTRY CLIENTS, 1982-83 AND 1983-84

Source of Referral	Number of Clients Referred 1982-83	1983-84
Hospital, Clinic or Physician	142 (44%)	90 (33%)
Friends	68 (21%)	68 (25%)
Schools	42 (13%)	53 (20%)
Social Service Agencies	33 (10%)	30 (11%)
Dept. of Social Services	20 (6%)	17 (6%)
Planned Parenthood	6 (2%)	2 (1%)
Other	5 (2%)	5 (2%)
Unknown	6 (2%)	6 (2%)
TOTAL	322 (100%)	271 (100%)

TABLE 13A. REFERRING AGENCIES OR SOURCES FOR PREGNANT TEEN CLIENTS, 1983-84

SFGH	56
Friend/Family Member	35
Mt. Zion Hospital	13
Dept. of Social Services	10
Balboa High School	7
Health Center #3	4
San Francisco Unified School	4
Downtown High School	3
Mission Neighb.Hlth.Ctr.	3
Unknown	3
Wilson High	3
Youth Guidance Center	3
Alamo Park High Sch.	2
Hickman Home	2
Kaiser	2
Community Agency	2
Planned Parenthood	2
RAP(Real Alternatives Program)	2
St. Elizabeth's	2
Sunshine High	2
T.A.L.K. Line	2
Casa de las Madres	1
Catholic Social Services	1
Center for Ind. Study	1
Immaculate Conc. High Sch.	1
Laguna Honda Hospital	1
McAuley Institute	1
Mission High School	1
Monteagle Medical Bldg.	1
Native American Hlth.Ctr.	1
Pelton Jr. High School	1
Proj. Stay at School	1
St. Pauls School	1
Salvation Army	1
South East Health Center	1
U.C. Medical Center	1
Visitacion Valley Mid. Sch.	1
Women's Needs Center	1
Youth for Service	1

TOTAL CLIENTS 180

TABLE 13B. REFERRING AGENCIES OR SOURCES FOR ENTRY MOTHER CLIENTS, 1983-84

Department of Social Services	7
SFGH	5
Friend/Family Member	3
St. Elizabeth's	3
Health Center #1	2
Kaiser	2
Ad on Radio	1
Balboa High School	1
CASARC	1
Child Protective Services	1
Emergency Family Care	1
Aid for Families with Dependent Children	1
Health Center #3	1
Health Center #5	1
Hickman Home	1
Mission Neighborhood Hlt.Ctr.	1
Mt. Zion Hospital	1
St. Lukes	1
San Francisco Unified School	1
Florence Crittenton	1
Youth Guidance Center	1
TOTAL CLIENTS	37

TABLE 13C. REFERRING AGENCIES OR SOURCES FOR MALE CLIENTS, 1983-84

ENTRY FATHERS

Friend/Family Member	7
Unknown	3
Balboa High School	2
Radio Ad	1
SFGH	1
Youth Guidance Center	1
TOTAL CLIENTS	15

EXPECTANT FATHERS

Friend/Family Member	20
RAP	3
Unknown	3
Youth Guidance Center	2
San Francisco Unified School	2
Ella Hill Hutch Center	1
Health Center #3	1
Planned Parenthood	1
Portrero Hill Health Ctr.	1
SFGH	1
TOTAL CLIENTS	35

The wide diversity of referring agencies shown in these tables (13A, B and C), demonstrates the high degree of networking among local agencies in the effort to enroll clients in a comprehensive program while not statistically significant. This year there was an increased diversity of agencies referring clients to TAPP as compared to the previous year.

Residence of New Tapp Clients

TAPP has established a city-wide network of services that enables any pregnant or parenting adolescent under the age of 17 to receive comprehensive services. Within the city, however, there are specific geographic areas which require special focus due to the large numbers of adolescents in need, as well as the limited number of available social and medical services. For example, for the period of October 1, 1982 through September 30, 1983, Health Districts I, II and III accounted for 65% of all births to San Francisco residents age 12-17. The teen birth rate was significantly higher in these districts as compared to the two remaining districts in the City of San Francisco.

In that year, the TAPP program enrolled and provided services to 43% of adolescents who gave birth while residing in those health districts. For the 1983-84 program year, there has been a significant effort to increase the enrollment of these high risk youth in the TAPP program. Seventy seven percent of the new clients entering the program this year reside in those three districts compared to 43 percent for last year, statistically significant at $P < .05$). Table 14 summarizes the entry status, as well as the residence by health districts of clients entering the TAPP project in 1983-84. Birth data for 1984 is currently not available so we are unable to ascertain the birth rate for these health districts at this time.

TABLE 11 [illegible]

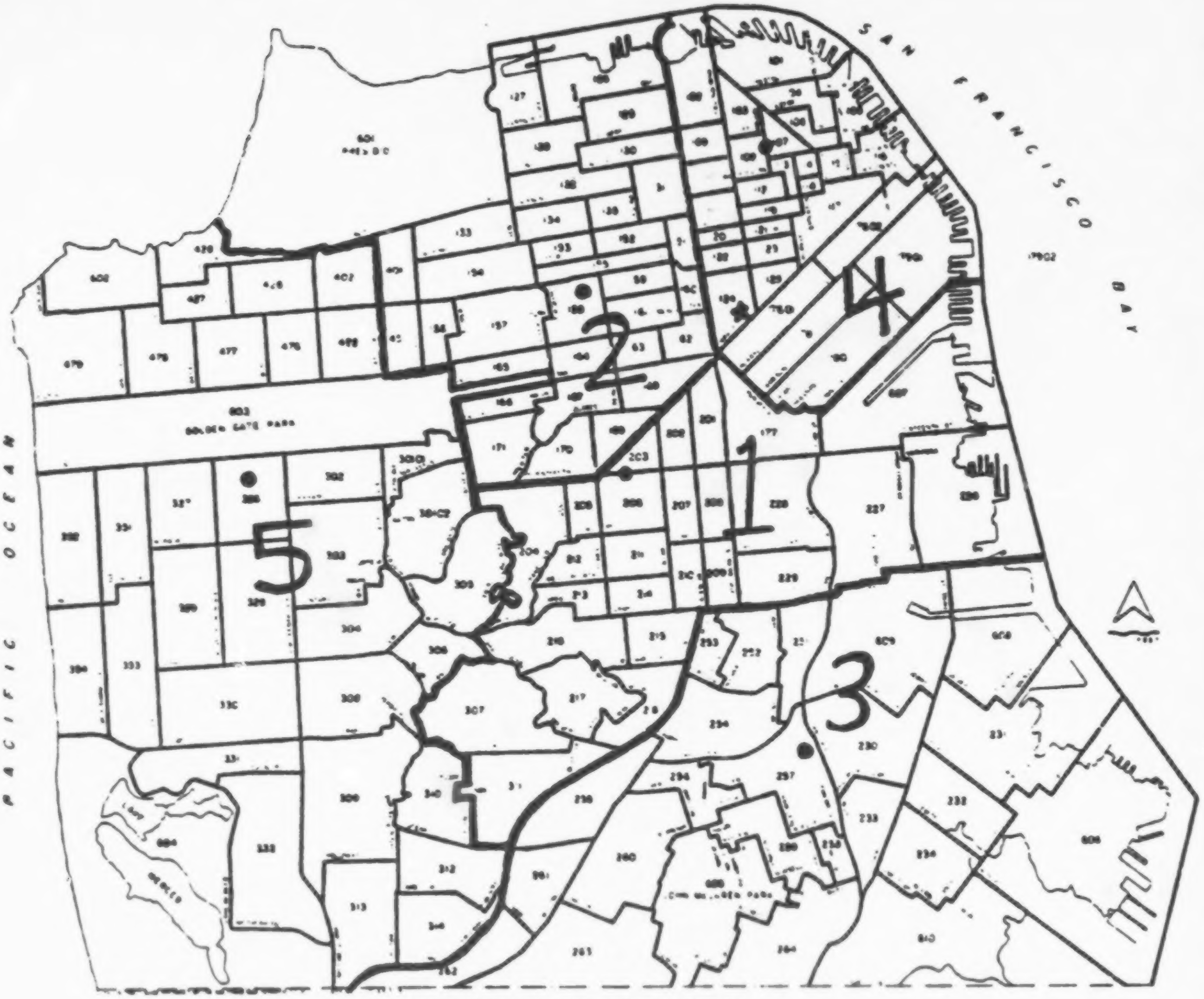
By Health District - 1983-1984

Entry Status:	Pregnant	Entry Mothers	Other Female Teen	Expectant Fathers	Father	Not Father	Total	
DISTRICT:								
1. Mission *	44	13		15	4		76	29%
2. Westside *	23	4		3	4		34	14%
3. Southeast *	68	10	2	14	5		99	37%
4. Northeast	12	4	1	2			19	7%
5. Richmond/ Sunset	27	5			1		33	12%
Other/Unknown	4	1	1	1	1	2	10	1%
Total	178	37	4	35	15	2	271	100%

---

*District targeted by TAPP

FIGURE 1
SAN FRANCISCO HEALTH DISTRICTS


PACIFIC OCEAN
SAN FRANCISCO BAY
601 PRESIDIO
603 GOLDEN GATE PARK
1
2
3
4
5

1980 CENSUS TRACTS

District 1 (Mission)*

177
201 - 218
226 - 229
307 - 311
607

District 2 (Westside)*

126 - 135
151 - 171
401
451
601

District 3 (Southeast)*

230 - 234
251 - 264
605 - 606
608 - 610

District 4 (Northeast)

101 - 125
176
178 - 180

District 5 (Richmond/Sunset/OMI)

301 - 306
308 - 310
312 - 314
326 - 332
351 - 354
402
426 - 428
452
476 - 479
602 - 604

Dots (.) - represent health Department
Star (*) - represents Central Department Office.

SAN FRANCISCO DEPARTMENT OF CITY PLANNING

BEST COPY AVAILABLE

Profile of Clients' Partners

Demographic data collected since 1982 on male partners who were themselves either TAPP clients or not enrolled in TAPP shows that the average age of female clients' partners was between one and three or more years older than the average age of the females themselves (Tables 2 and 15). As in 1982-1983, the majority of female clients entering TAPP were 16 or 17 years old, while 34 percent of their partners were over age 19 and another 33 percent were 18 or 19. The decrease from 41 percent (in 1982-83) to 34 percent (in 1983-84) of males over the age of 19 enrolled in the program demonstrates the greater emphasis placed on targeting the enrollment of younger males for the TAPP project.

A majority of both the male partners and female partners were unemployed (58 percent and 86 percent, respectively). The larger percentage of males employed (significant at $P < .05$) may be reflective of the finding that the males tend to be older. It may also reflect that women rather than men are the ones who take primary care of the children.

Among new clients, there was a slight increase (from 28 percent to 31 percent) of male partners not enrolled in TAPP who had dropped out of school and, a decrease (from 34 percent to 31 percent) in the number of males who had graduated from school. Females in this group were for the most part attending school (55 percent) or were already high school graduates (10 percent). Thirty-five percent of the female partners had dropped out, as compared to the 42 percent who had dropped out in 1982-83.

TABLE 15 AGE, EMPLOYMENT AND SCHOOL ENROLLMENT OF PARTNER, 1982-83, 1983-84

	Age					
	Under 14	14 - 17	18 - 19	Over 19	Unknown	Total
MALE PARTNER OF TAPP CLIENT						
1982-83	-	82 (32%)	66 (26%)	104 (41%)	4 (2%)	256 (100%)*
1983-84	-	65 (30%)	73 (33%)	74 (34%)	7 (3%)	219 (100%)*
FEMALE PARTNER OF TAPP CLIENT						
1982-83	-	57 (86%)	7 (11%)	1 (2%)	1 (2%)	66 (100%)*
1983-84	2 (4%)	41 (80%)	7 (14%)	1 (2%)	-	51 (100%)*

	Employed	Unemployed	Unknown	Total
MALE PARTNER OF TAPP CLIENT				
1982-83	78 (30%)	165 (64%)	13 (5%)	256 (100%)*
1983-84	68 (31%)	127 (58%)	24 (11%)	219 (100%)*
FEMALE PARTNER OF TAPP CLIENT				
1982-83	4 (6%)	60 (91%)	2 (3%)	66 (100%)*
1983-84	7 (14%)	44 (86%)	-	51 (100%)*

	Attending	Dropped Out	Graduated	Unknown	Total
MALE PARTNER OF TAPP CLIENT					
1982-83	77 (30%)	72 (28%)	87 (34%)	20 (8%)	256 (100%)*
1983-84	63 (29%)	67 (31%)	69 (31%)	20 (9%)	219 (100%)
FEMALE PARTNER OF TAPP CLIENT					
1982-82	32 (48%)	28 (42%)	4 (6%)	2 (3%)	66 (100%)*
1983-84	28 (55%)	18 (35%)	5 (10%)	-	51 (100%)*

*Percentages do not total 100 due to rounding.

Profile of Exited Clients

Of the 235 clients who exited the program in 1983-1984, (Table 16), sixty percent had entered the program as pregnant teens, 16 percent as entry mothers, 15 percent as expectant fathers and seven percent as entry fathers. Other female teens and other males each constituted one percent of the sample.

The transitory nature of this client population is reflected in the primary reasons why the clients exited the program. Twenty-three percent had moved away, while another 19 percent were lost to follow up. A client was defined as "lost to follow up" if there is no response to phone calls, followed by a letter and a home visit. Other teens requested to end their program involvement (21 percent). Twenty-five percent of those exiting left on a successful note, judged by the staff to be self-sufficient in their ability to identify and participate in educational and employment alternatives, as well as utilizing social services effectively. Nine percent left the program because their ages had exceeded the program guidelines of providing services for adolescents, seventeen and under. In these cases, Case Managers worked with clients in their transitions to other Social Service Systems. The demand for services among younger adolescents also required that staff devote their attention to these high risk adolescents. The remaining 3 percent left for miscellaneous reasons.

Table 17 summarizes the time spent in the TAPP program by exiting clients and shows an overall increase in the amount of time clients received assistance. Almost half of exiting clients (46 percent) left the program after having participated in a minimum of one and a maximum of two years. This contrasts sharply with the previous program year, in which only 17 percent were enrolled for that period of time (statistically significant at $<.05$).

TABLE 16. REASON FOR EXITING BY ENTRY STATUS, 1982-83 AND 1983-84

Reason	Pregnant	Entry Mother	Other F. Teen	Expectant Father	Entry Father	Other Male	Total
Moved							
1982-83	17	8	2	2	-	-	29 (21%)
1983-84	34	9	1	7	2	-	53 (23%)
Requested End/Not interested							
1982-82	23	6	-	1	2	-	32 (24%)
1983-84	25	1	-	6	2	-	51 (21%)
Can't Locate							
1982-83	25	20	1	2	2	1	51 (38%)
1983-84	23	10	-	7	6	-	46 (19%)
Self-Sufficient							
1982-83	15	4	-	-	1	-	20 (14%)
1983-84	21	16	1	6	2	1	57 (25%)
No Longer Eligible							
1982-83	-	-	-	-	-	-	-
1983-84	17	-	-	3	-	1	21 (9%)
Other							
1982-83	3	-	-	1	-	-	4 (3%)
1983-84	5	1	-	1	-	-	7 (3%)
Total							
1982-83	83 (61%)	38 (28%)	3 (2%)	6 (4%)	5 (4%)	1 (< 1%)	136 (100%)
1983-84	140 (60%)	38 (16%)	3 (1%)	36 (15%)	16 (7%)	2 (1%)	235 (100%)

The number of clients who dropped out within six months decreased by nearly 50 percent (from 52 percent in 1982-1983 to 27 percent in 1983-1984), (statistically significant at $P < .05$). Almost a third of all clients exiting received between six and 12 months of assistance.

Entry mothers tended to have stayed in the program longer than pregnant teens. Sixty-three percent of the entry mothers as compared to 51 percent of the pregnant teens received services between one and two years. Approximately 26 percent of the pregnant teens stayed in the program between six months and one year, as compared to seven percent of entry mothers. While the majority of teens are staying on the program at least six months, these findings indicate the strong need that the clients experience for services long after they have given birth.

TABLE 17. TIME IN PROGRAM OF EXITED CLIENTS, BY ENTRY STATUS, 1982-83 and 1983-84

	Pregnant	Entry Mother	Other F. Teen	Expectant Father	Entry Father	Other Male	Total
Under 3 Mos.							
1982-83	25	9	1	2	1	1	39 (29%)
1983-84	15	4	-	8	-	-	27 (12%)
3 Mos.- 6 Mos.							
1982-83	19	9	-	1	2	-	31 (23%)
1983-84	17	7	2	5	4	-	35 (15%)
6 Mos.- 1 Year							
1982-83	25	14	-	2	1	-	42 (31%)
1983-84	37	3	-	14	9	1	64 (27%)
1 Year - 2 Years							
1982-83	14	6	2	1	1	-	24 (17%)
1983-84	71	24	1	9	3	1	109 (46%)
Total							
1982-83	83	38	3	6	5	1	136 (100%)
1983-84	140	38	3	36	16	2	235 (100%)

IMPLICATIONS OF RESULTS/FINDINGS

In its third year of operations, the TAPP project has continued to expand, reaching and providing ongoing services to an increasing number of San Francisco's pregnant and parenting adolescents. While there has been a decrease of approximately 50 new clients in this year's program, there has been an overall increase in the total number of clients served by the program. The decrease may reflect a demographic shift in the number of adolescents and consequently the potential number of pregnancies among teenagers.

It may also reflect the initial rapid growth of the program in "catching up" with the pool of potential program recipients. TAPP has successfully targeted two specific high risk groups - pregnant adolescents and young fathers or fathers to be. Thus, two thirds of the clients are pregnant and nearly 20 percent are males. Within these groups, TAPP has successfully enrolled those youth at highest risk particularly those age 17 and below.

While TAPP is a city wide program, it has aimed at reaching clients with the highest needs; 77 percent of this years' clients, reside within the three health districts which accounted in 1982-83 for 65 percent of the city's births to adolescents (many of the births occur to clients from a variety of ethnic minorities). TAPP has been effective in reaching those populations in need of services; 78 percent of new clients were Black or Hispanic. This figure is higher than the ethnic profile of TAPP clients delivering in San Francisco County in 1982-1983. In that year, 43 percent of all births under the age of 17 in San Francisco occurred to Black adolescents and 31 percent to Hispanic adolescents.

The comprehensive, social, psychological and medical approach exemplified by TAPP enables the program to have a wide scope of services which are made available not only to the pregnant clients, but to "significant others" involved in the dynamics of their lives. As the clear majority of clients live with their parents, familial involvement is clearly appropriate and facilitated through the program. In terms of schooling, there have been increased number of clients, who have either graduated or are attending school when they enter the project. While over half of the pregnant adolescents were enrolled in school at the time they entered the program, almost 60 percent of TAPP teen mothers had dropped out. Thus, while there appears to be an improvement in the school status of the pregnant adolescent, the need for a supportive program which advocates school continuation for the teen mother is imperative. TAPP may tend to get teen mothers out of the program because those doing okay in school are considered "self-sufficient". This is shown also in the dropout rates of Pregnant Minors Program Clients at seven months (Table 28).

The positive effects of TAPP's agency networking is reflected in the kinds of referral patterns which have emerged. Social service agencies, school, and "word of mouth" referrals were important in identifying high risk adolescents and demonstrate how inter-agency linkages assist in providing appropriate services to clients. While medical clinics and physicians play a significant referral role, the social agency referrals help create an integrated approach to the identification and reaching of high risk clients.

Along with family involvement, male partners are recognized as a potentially important resource for the adolescent and her family. The usual pattern of an older partner and the age restrictions established by the Fatherhood project necessitates that the agency examine how they could best serve this needy population. Few other service agencies target those male youths 19-24 who are as much in need of services as younger male fathers.

The demand for TAPP services and client loads maintained by the case management staff has required a careful review of clients enrolled in the program. Approximately 42 percent left the program prematurely either because they had moved away or were lost to follow-up. Another 25 percent left successfully because no further needs for program services were apparent. TAPP has become more successful in retaining program enrollees a minimum of one year. It is this ongoing contact and relationship between client and case manager through time which enables a positive impact on the lives of both the client and their infants.

Continuity of care, from pre-natal through post-natal is important in assuring program success. The TAPP program gives equal stress to post-natal services as it does to pre-natal services, thus assuring that continuity of care is maintained.

EVALUATION OF OUTCOMES

PART II

LOW BIRTHWEIGHT BIRTHS TO TEENS IN TAPP

PROBLEM STATEMENT

Babies of low birthweight are at greater risk of chronic illness, developmental disabilities and death. Teen mothers, particularly those under 18 years of age, are more likely to have low birthweight babies. Although the low birthweight rate to teens in TAPP in 1983-84 was lower (11.4%) than that expected for teens of their age and race in San Francisco County (14% for 1982-1983, the most recent data available), the rate was higher than in the previous years (8 percent), a difference not statistically significant. The problem is, how can TAPP further reduce the occurrence of low birthweight babies?

INTERVENTION STRATEGY

TAPP uses centralized case management to see that pregnant teens get certain group and individual counseling sessions, nutrition education and counseling, career development classes, school enrollment, health and child development education, prenatal care, food programs, Medi-Cal and AFDC services.

(See Part III - Case Management Study for additional details on program interventions).

EVALUATION METHODOLOGY

OBJECTIVES AND HYPOTHESIS. The objective of this part of the evaluation is to discover 1) which aspects of the TAPP case management program are associated with lowest rates of low birthweight births, and 2) to find out which TAPP participants are at highest risk of low birthweight births.

The aim is to reduce low birthweight births by increasing participation of the clients at highest risk in the aspects of the TAPP program with lowest associated incidences of low birthweight. More specifically, the working hypothesis was that the existance of case management within the Pregnant Minor's Program (PMP) was associated with the highest use of direct services at TAPP which in turn was associated with the lowest rates of low birthweight.

DATA AND ANALYSIS. Data was obtained from the TAPP Data Base for 167 pregnant clients who gave birth in 1983-84, regardless of their year of entry into the program. Information for the data base was entered on forms by the case manager responsible for each pregnant teen and transferred to a micro-computer by the data base manager. We received output cross-tabulations and performed pair-wise statistical comparisons using chi-square analysis. For purposes of analysis, twins were counted as a single birth. In all cases, twins were both less than 2500 grams and were counted as a single low birthweight birth.

Data was analyzed by "Track." The TAPP program has been traditionally divided for research purposes into "Tracks" determined by participation in the PMP program and sources of prenatal health care. Clients in Tracks 1 and 2 both obtain health care at San Francisco General Hospital (SFGH) or Mt. Zion Hospital. Clients in Track 1 receive schooling together in a Pregnant Minor Program (PMP) where case managers are based. Pregnant Teens in Track 2 have graduated, withdrawn from school or attend school at other than a PMP and therefore are not attending school where case managers are based. Clients in Tracks 3 and 4 obtain their health care from sources other than SFGH or Mt. Zion, either clinics at other hospitals, or from private practitioners. Participants at Track 3 receive their schooling at a PMP where case managers are located, while those in Track 4 have graduated, withdrawn from school or attend school at other than the PMP and maintain an ongoing relationship outreach and community placements of the TAPP case managers.

The amount of TAPP direct services were measured in 15 minute units of time segments spent with a case manager, public health nurse or other staff. Types of units of service included were: individual and group psychosocial sessions, health education, nutrition, career and child development.

A. RESULTS:

COMPARISON OF RATES OF LOW BIRTHWEIGHT BIRTHS BY CASE MANAGEMENT TRACKS.

The rates of low birthweight are lowest in Tracks 1 (7.7%) and 3 (8.2%) in which the teens received schooling where Continuous Counselors were also based (Table 18). The rates of low birthweight are highest in Tracks 2 (13.3%) and 4 (18.2%) in which the teens were either not in school or their schooling was not at the same site as their case managers. Though there were insufficient births in the data from a single year to establish that the differences are statistically significant (in preparation). Thus, lowest low birthweight rates are associated not with the source of health care (Tracks 1 and 2 compared with Tracks 3 and 4), but with whether or not the pregnant teen is in an educational PMP with Continuous Counselors available on site.

When the births are regrouped according to school status, lowest rates of low birthweight are associated with attending a PMP (8.0 percent, Table 19). Highest rates of low birthweight are associated with those pregnant teens who withdraw from school (dropouts) (16.7 % P.05). The low birthweight rates are intermediate for those who have graduated or attend school at other than a PMP and not significantly different from either of the other groups.

The primary characteristic of the TAPP program that could explain the differences in low birthweight rates is the differences in amounts of direct services given clients in the different school settings. Participants in the PMP have the highest average number of units of service (161.0 per

TABLE 18 Incidence of low birthweight births (1983-1984) by Tracks based on source of health care for the pregnant teen mother.

	Health Care	Schooling	Number of Births	Low Birthweight Births number	Low Birthweight Births percent
TRACK 1:	SFGH, Mt.Zion	PMP	26	2	7.7%
TRACK 2:	SFGH, Mt. Zion	Other Than PMP[1]	49	6	13.3%
TRACK 3:	Other Than SFGH[2]	PMP	6%	6	8.2%
TRACK 4:	Other Than SFGH or Mt. Zion	Other Than PMP[1]	33	6	18.2%
TOTAL			167	19	11.4%

1. Schooling other than PMP (Pregnant Minors Program) means the mother was in school elsewhere, had graduated or withdrawn.

2. Health Care other than SFGH (San Francisco Genral Hospital) or Mr. Zion Hospital means other clinic or other private doctor.

TABLE 19 Incidence of low birthweight births (1983-1984) by school status of the pregnant teen mother.

Schooling	Health Care	Number of Births	Low Birthweight Births number	Low Birthweight Births percent
PMP	SFGH, Mt. Zion or Other	87	7	8.0%
Other Schooling or Graduate[1]	SFGH, Mt. Zion or Other	26	3	11.5%
Not in School (dropout)	SFGH, Mt. Zion or Other	54	9	16.7%
TOTAL		167	19	11.4%

---

[1] Includes 7 graduates (one low birthweight birth) the rest of the mothers (19) are in schools without PMP (two low birthweight births).

teen giving birth Table 20). Those in other schooling or graduates received the lowest units of service (46.3 per teen giving birth). The average units that school dropouts received was also low (65.0) per teen giving birth). Analysis of utilization of case management services by individual clients is not possible at this time because of the unavailability of individual data.

Before concluding that the PMP has lower incidences of low birthweight births because of increased TAPP involvement with these clients, one should investigate if other differences between participants in the PMP and school dropouts exist which could explain the association observed. There are certain limitations of the analysis that preclude proving whether or not the direct services are the reason the teens in the PMP have fewer low birthweight babies. First, there is the self selection bias of the teens because this is an observational and not a randomized study. It could be that part or all of the difference in low birthweight rates is because teens that are likely to take care of themselves choose the Pregnant Minor Program. This bias cannot be removed without the arbitrary, and unethical, random assignment of different teens to the Pregnant Minor Program. We can reduce but not eliminate this limitation on the interpretaton of the findings by controlling for all the characteristics that might afect birthweight between the groups, and see if the low birthweight rtes persist. There are not enough births to allow a multi-variate analysis. But we can first analyze the characteristics of pregnant TPP clients associatd with low birthweight birthweight births, and then investigate the extent o which these risk factors are present in the prenatal clients who partcipate in PMP and the prenatal clients who do dropout of school. If partiipants in the PMP have lower incidences of the risk factors, this might expain their better low birthweight rates independednt of the unit of TAPP srvices.

TABLE 20 Average number of units of service (15 minutes of counseling or class equals one unit) per prenatal client for the various services provided.

	Number of Public Prenatal Clients	Average Units of Service Per Prenatal Client							
		Health Nurse	Psychology	Group Psychology	Health Education	Nutrition	Career Development	Child Development	All services
PMP	87	11.5	21.0	33.7	42.5	25.7	19.6	6.9	161.0
Schooling or Graduate[1]	26	4.2	26.8	8.9	1.8	2.9	2.0	0.77	46.3
Not in School (dropout)	54	14.1	26.4	6.8	7.2	5.2	4.2	1.1	65.0

---

[1] See Footnote (1) Table 2.

COMPARISON OF RATES OF LOW BIRTHWEIGHT BIRTHS FOR DIFFERENT CHARACTERISTICS PREGNANT TEENS. Initially we wished to examine whether the reason that PMP clients had lower rates of low birthweight occurred as a result of their being at lower risk of birthweight for other reasons rather than because they received higher units of TAPP direct services. We first examined ten other reasons babies might have had low birthweights, and then investigated whether PMP participants had fewer of these high risk types of births. Established high risk factors for low birthweight births in the general populaton are (1) inadequate prenatal care; (2) black ethnicity; (3) maternal ages less than 18 years; (4) no previous pregnancies; (5) no previous births; and, (6) being unmarried are included in the ten risk factors studied (Table 21).

Of the ten risk factors investigated (Table 21), only two risk factors reached statistical significance using the births to pregnant teens from a single year: (1) less than 10 prenatal care visits; and, (2) non-participation of the pregnant teen in a food supplement program (WIC or other Federal Program). For the clients in the food programs the low birthweight rate was 9.0%, for those not enrolled, the rate was 14.3. For clients with 10 or fewer prenatal care visits the rate of low birthweight births was 23.6%, for those with more than 10 it was 3.4%. One possibly confounding factor with this risk factor as measured is that, the shorter the gestation the less time available for prenatal visits and the more likely the baby will be low birthweight. Thus prenatal care should be assessed by number of visits adjusted for length of gestation. This is not possible now with the data available but should be investigated in the future. These differences in the unadjusted rates with prenatal care, however, are so striking that the adjustment may reduce, but not remove, the association of prenatal care visits and lower rates of low birthweight births.

TABLE 21 Incidence of low birthweight births (1983-1984) in various groups of pregnant TAPP clients.

	Number of Births	Low Birthweight Births		Relative Risk +
	N‡	n	percent	
Prenatal Care Visits				
Ten Visits or less	55	13	23.6% *	2.10
Eleven visits or more	87	3	3.4% *	
Food Supplement Program -				
Participant	133	12	9.0% *	
Non-participant	29	6	20.7% *	1.86
Ethnicity				
Black	86	13	15.1%	1.33
Non-Black	81	6	7.4%	
Age				
12-14	7	0	0%	-
15-17	122	13	10.6%	0.94
18	38	6	15.8%	1.34
Previous Pregnancy				
None	125	12	9.6%	
one or more	42	7	16.7%	1.46
Previous birth				
None	154	16	10.4%	
One or more	13	3	23.1%	2.03
Living Arrangement				
Parents (with or without partner)	105	13	12.4%	0.95
Spouse/Partner	19	1	5.3%	0.40
Alone	14	4	28.6%	2.19
Marital Status				
Single	146	16	11.0%	
Married	21	3	23.1%	1.26
Medi-Cal for Prenatal care				
Yes	114	13	11.3%	
No	42	6	14.3%	1.17
AFDC				
Yes	86	9	10.5%	
No	81	10	12.3%	
Medi-Cal &/or AFDC				
Yes	121	13	10.7%	
No	46	6	13.0%	
Special Education				
Yes	15	2	13.3%	
No	137	17	12.4%	

+ Relative Risk is the ratio of the occurrence of the risk in low birthweight births to the occurrence of the risk in all births.

‡ Where total number of births for any category is less than 167, the balance of births are missing data.

* Statistically significant at least at the P.05 level.

BEST COPY AVAILABLE

Other risk factors approaching statistical significance with only one year's data are 1) Black ethnicity: 2) increasing age; 3) previous pregnancy or birth; and 4) living alone. Black ethnicity is a high risk factor for these teens as it is in the general population (15.4% low weight births to Blacks compared with 7.4% to non-Blacks). However, all other risk factors for these pregnant teens are the reverse of established high risk factors affecting the general population. For pregnant teens participating in TAPP, the older the teen was the more likely she was to have a low birthweight baby. Although the numbers are small, the trend is striking and understandable when the incidence of repeat births is taken into account. Clients who had had a previous pregnancy or previous births were more likely to have a low birthweight birth. For the general population, first births (Primiparas) are at higher risk of low birthweight births than second and third births. However, for teenage mothers, low birthweight rates are greater for their second and third children. One major reason for these poorer outcomes is likely to be the closer spacing of repeat births to teens than older women. All three low birthweight repeat births in the TAPP Project were within 12 months of the previous birth, only one baby born within a year weighed more than 2500 grams. In a study by the National Center for Health Statistics, 17% of first pregnancies,22% of second, and 50% of third pregnancies among adolescents resulted in low birthweight infants (NCHS, 1979).

Interesting differences in rates of low birthweight births appear when the pregnant clients are compared according to their living arrangements. Those living with spouses or partners tended to have the lowest rate (5.3%), while those living alone had the highest rate (28.6%). Those living with parents (with or without their partners or spouses in the house) had an intermediate (12.4%).

While the results of this analysis did not find any association between

TABLE 22 Proportions of pregnant teens (1983-1984) with risk factors for low birthweight births by school status.

	Prenatal Care Visits ≤ 10		Food Program non-participation		Ethnicity: Black		AGE (Years)						Previous Pregnancy(ies)		Previous Birth(s)		Living Arrangements					
							12-14		15-17		≥ 18						with parents *		with spouse/partner		Alone	
	n	percent	n	percent	n	percent	n	percent	n	percent	n	percent	n	percent	n	percent	n	percent	n	percent	n	percent
PMP N=87	30	42%	15	18%	53	61%	6	7%	68	78%	13	15%	16	18%	3	3%	70	80%	3*	3% *	7	8%
Other Schooling or Graduated N=26	7	21%	7	27%	14	54%	0	0%	18	69%	8	31%	10	38%	4	15%	16	61%	3	12%	4	15%
Not in School (Dropout) N=54	19	40%	7	13%	19	35%	1	2%	36	67%	17	31%	16	30%	6	11%	32	10%	13	24%	5	9%

* Living with parents, includes pregnant teens, with or without partner or spouse. These proportions do not add up to 100% because the category "other" is not included in the Table.

BEST COPY AVAILABLE

low birthweight rates and marital status, Medi-Cal reimbursement for prenatal care, or status as special education student for TAPP clients, when larger numbers of clients are studied differences may be established. Thus, further analysis is necessary to study the association of risk factors with outcomes for the babies.

COMPARISON OF RATES OF THE CHARACTERISTICS ASSOCIATED WITH LOW BIRTHWEIGHT BIRTHS IN THE CASE MANAGEMENT SCHOOLING TRACKS Because certain characteristics of pregnant teens tend to be associated with higher chances of low birthweight births, we are now ready to re-examine the findings that participation in the PMP was associated with lower chances of low birthweight births because of greater intensities of TAPP direct services. If PMP participants happened to be at lower risk of having a low birthweight baby (such as being non-Black), it then could be questioned whether the association between PMP and low rates of low birthweight births was due to the TAPP direct services associated with this school status. However, from Table 22 it can be generally concluded that PMP participants do not have lower rates of risk factors for low birthweight births: 42% of PMP pregnant clients had 10 or fewer prenatal care visits (compared with 40% of the school dropouts, with highest low birthweight rates); 18% of PMP clients did not participate in a Food Program, compared with 13% of school dropouts; Black clients formed 61% of the PMP population, but only 35% of the school dropouts. Further analysis of the Black clients in these two groups is possible because of the large numbers of pregnant teens served in this risk category (Table 23). When the rate of low birthweight births to Black teens in the PMP is compared to those in the school dropout group, the differences are striking and statistically significant. Some 11.3% of Black PMP participants had low birthweight births, but 31.6% of Black clients who had dropped out of school had low birthweight births. This is the highest rate of low birthweights observed for any group examined.

BEST COPY AVAILABLE

TABLE 23 Low birthweight births of TAPP clients by ethnicity and school status.

Ethnicity of Mother	Black			non-Black		
		low birthweight births			low birthweight births	
	number of births	number	percent	number of births	number	percent
PMP	53	6	11.3%	34	1	2.9%
Other Schooling or graduated	14	1	7.1%	12	2	16.7%
Not in School Dropout	19	6	31.6%*	35	3	8.6%
Overall	86	13	15.1%	81	6	7.4%

** Statistically higher than Blacks in school or graduated (PMP and others combined) (P.05)

BEST COPY AVAILABLE

The age distribution for PMP teens should have put them at increased risk for low birthweight births: 85% were under age 18, 7% under age 15. This is contrasted with the clients who had dropped out of school, with 69% under age 18 and 2% under age 15. However, further analysis is needed to determine the risk of low birthweight in the different age groups of teens. Only 3% of those in the PMP tracks live with spouses or partners compared with 24% of those who had withdrawn from school. Although 80% of PMP clients lived with their parents(with or without their partners or spouses) compared with 18% of school dropouts, this characteristic was not associated with improved rates of low birthweight births in TAPP (Table 21). Thus, the only hight risk characteristic of the pregnant teens in PMP that might partially explain their lower rates of low birthweight births is that 3% of PMP clients had previous births, whereas 11% of the school dropouts had previous births (Table 22). However, this factor could only explain at most a 1% higher (9%) low birthweight rate, or 11% of the difference. The rest of the difference is likely to be associated with the greater utilization of TAPP services in the PMP's in which case managers are located at the same location as the schooling. While there are not sufficient cases in a single year to investigate this fully with a multi-variant analysis,the groundwork has been established that eliminates other likely explanations for the observed findings.

IMPLICATION OF RESULTS

The analysis of low birthweight births for 1982-83 indicates that TAPP clients in the pregnant Minor Program, who have their schooling and Continuous Counselor at the same site, have a lower rate of low birthweight births than school dropouts. This occurred in spite of the fact that the pregnant teens in Pregnant Minor Program do not have lower levels of risk for low birthweight briths than school dropouts. The participants in the Pregnant Minor Program generally received more direct services participating in more than twice as many units of service.

BEST COPY AVAILABLE

Increased utilization of case management services is likely, therefore to be the reason that participants in the Pregnant Minor Program have lower rates of low birthweight births. This finding can be strengthened with further analysis of: (1) the different types of units of particular services (e.g., Nutrition and Health Education); (2) measures of utilization other than average number of units; (3) the variation in the average levels of utilization to determine significant differences between groups; (4) units of service given to mothers who eventually had low birthweight babies compared to mothers who did not; and, (5) data from the previous year's births to TAPP clients. It is possible that the difference in low birthweight rates between PMP participants and school dropouts is due to some factor that was not qualified on the data base, such as self-esteem or motivation. We intend to do further investigation of these factors and their relationship to the Pregnant Minor Program. At Present, the best explanation of the better low birthweight rates of clients in the Pregnant Minor Program is the increased utilization of TAPP services by the PMP pregnant teens.

Client characteristics associated with highest rates of low birthweight are Black ethnicity and having dropped out of school. Indirect services associated with lowered rates of low birthweight births, are food programs and prenatal care visits. To reduce the occurence of low birthweight briths in TAPP, it appears that case managers need to promote further participation in the PMP, food programs, and prenatal care. These efforts whould be particularly directed to those pregnant teens at highest risk: Black teens who have left school; older teens, particularly those who already have one or more babies; or teens who live alone.

SCHOOL CONTINUATION RATES FOR FEMALE CLIENTS PREGNANT AT ENTRY TO TAPP.

PROBLEM STATEMENT

To promote the likelihood that the teens will be productive members of society it is important that they progress in their education as far as possible. Graduation from high school is a primary aim.

INTERVENTION STRATEGY

TAPP uses centralized case management to see that pregnant teens in need as well as eligible teens who have already given birth get counseling, group support sessions, and assistance in identifying child care arrangements, in order to reduce barriers to school continuation (See Part III - Case Management Sudy for additional details on program interventions).

EVALUATION METHODOLOGY

OBJECTIVES AND HYPOTHESES. The working hypothesis is that the Pregnant Minors' Program (PMP) was associated with the highest utilization of case management services at TAPP, which in turn should be associated with the lowest rates of school discontinuation. The objective of this part of the evaluation is to find out which aspects of the TAPP case management program during pregnancy are associated with the highest rates of clients later dropping out of school. Ultimately, the aim is to reduce school discontinuation by directing the aspects of the TAPP program with lowest associated incidences of school discontinuation at clients who have at highest risk of dropping out of school.

DATA AND ANALYSIS. Data was obtained from the TAPP Data Base for female clients who were pregnant at entry and due for follow-up in 1983-1984. They had entered between November 1981 and October 1984. Information for the data base was entered on cards by the case manager responsible for each teen and transfered to a microcomputer by the data base manager. We received output cross-tabulations and performed pair-wise statistical comparisons using chi-square analysis.

Data were analyzed by school status at entry to TAPP and at three follow-up points: birth, seven months postpartum, and one year postpartum. As clients exit the program (see Table 16 for reasons for exiting) they are no longer accounted for in the follow-ups.

RESULTS

COMPARISON OF SCHOOL STATUS AT ENTRY WITH SCHOOL STATUS WHILE PREGNANT. Almost half of the female clients who were not enrolled in school at entry to TAPP attended school after enrollment with TAPP (48 percent, Table 24). On the other hand, only 31% of the pregnant female clients enrolled in school at the time of entry to TAPP dropped out of school after enrollment in TAPP (significantly lower, $P < .05$). The availability of a Pregnant Minor Program to TAPP clients appears to increase the chances that a school dropout will return to school while pregnant: nearly four times as many (34 percent) of the TAPP pregnant clients who were school dropouts at entry enrolled in the Pregnant Minor Program during pregnancy compared with nine percent who enrolled in regular city schools (Table 26). Even pregnant females who were enrolled in a school at the time of entry to TAPP elected to transfer to the Pregnant Minor Program nearly three times as often (62 percent) as remain in their old school or transfer to another city school (22 percent).

Of the pregnant TAPP clients who decide to attend other than PMP schools while pregnant, 21 percent had been school dropouts at entry to TAPP, not significantly different from the 27% of PMP participants who had been dropouts at entry (Table 24). Significantly more of those who did not attend school during pregnancy (69%) were dropouts at the time of entry to TAPP. But pregnant teens who are dropouts at entry to TAPP are not as likely to remain dropouts (38 out of 67, 57 percent) as teens who are in school at entry tend to remain in school during pregnancy (84 out of 101, 84 percent, $P < .05$).

COMPARISON OF SCHOOL STATUS AT SEVEN MONTHS AFTER BIRTH WITH SCHOOL STATUS WHILE PREGNANT. For female clients who entered TAPP while pregnant, the school dropout rates at seven months after birth (Table 25) are not significantly different than the school dropout rates at entry to TAPP (Table 24) regardless of whether the teen attended a PMP, another school, or had been a dropout while

Table 24 School status at entry to TAPP of female prenatal clients in the various types of school programs while pregnant, regardless of follow up status.

At Entry / At Birth	Enrolled*		Dropout		Total	
	number	percent	number	percent	number	percent
PMP	62	73%	23	27%	85	100%
Other School	22	79%	6	21%	28	100%
Dropout	17	31%	38	69%**	55	100%
Total	101		67		168	

* * Significantly greater than the proportions of dropouts for the 'PMP' or 'Other School' categories ($P < .05$).

* None graduated.

BEST COPY AVAILABLE

Table 25 School status at birth and at seven months after birth, 1983-1984, for female clients pregnant at entry into TAPP.

7 months post partum / At Birth	In School or Graduated		Employed or Job Training		Dropout		Total	
	number	percent	number	percent	number	percent	number	percent
PMP	43	66%	7	11%	15	23%	64	100%
Other School	15	75%	3	15%	2	10%	20	100%
Dropout	12	33%	7	19%	17	47%	36	100%

BEST COPY AVAILABLE

entry to TAPP (Table 24) regardless of whether the teen attended a PMP, another school, or had been a dropout while pregnant.* For those attending a PMP school during pregnancy, the dropout rate is 23% at seven months after birth, whereas at entry to TAPP 27% had been dropouts (compare Tables 24 and 25). Only 10% of TAPP clients who attended schools other than PMP while pregnant had dropped out of school by seven months after birth; but 21% had been dropouts at times of entry to TAPP. The number of clients in this category, however, is too small for the improvement in school enrollment to be statistically significant. While 47% of those who had been dropouts during prenancy were dropouts seven months after birth, 69% were dropouts one year after birth. Though the number of clients in this category is larger, it is still too small for the difference to be statistically significant. Thus, while the trend is for school enrollment rates seven months after birth to have improved over school enrollment rates at entry to TAPP for those not in Pregnant Minors Programs (either in other schools or dropouts at entry), the difference is not significant with the numbers available. Since Pregnant Minors Program clients must leave their special school at the end of the semester in which the baby is born, their dropout rate seven months after the birth could reflect problems in returning to regular schooling.

Of special importance in interpreting the significance of these results is the assumption that those clients who have exited the program or have been lost to followup do not have different school dropout rate after exiting than those who remain in touch with the program. About 30% of clients have exited or are lost to followup at seven months after birth. However, at present there is no way of determining what proportions are dropouts.

---

* Note that a female teen employed or in job training is not considered a school dropout in this analysis. To analyze the overall dropout rate merely combine the numbers for 'dropout' with 'employed or in job training.'

COMPARISON OF SCHOOL STATUS AT ONE YEAR AFTER BIRTH WITH SCHOOL STATUS WHILE PREGNANT. While there are fewer clients followed through one year after birth, school dropout rates for female clients pregnant at entry to TAPP show the same general trends that they did at seven months after birth: school dropout rates for those who were in school during pregnancy are largely the same dropout rates that the groups had at entry to TAPP. One year after birth, 23 percent of Pregnant Minors Program clients are school dropouts, while 7 percent of those who attended other schools during pregnancy were dropouts (Table 26). As before, the numbers are too small to establish a statistical difference-but raise the question of the potential benefits of prolonging the Pregnant Minors Program school eligibility until graduation.

For clients who had been school dropouts at entry to TAPP, dropout rates one year after birth were as high as their rates at entry: 69% one year after birth compared with 69% at entry (Tables 24 and 26). However, by one year after birth, twice as many clients had exited or were lost to follow-up in the group who were dropouts at birth. For those in a PMP, 31 percent were lost to follow-up by one year after birth; for those in other schools during pregnancy, 44 percent were lost; for dropouts 69 percent were lost. The dropout rates in the clients lost to follow-up may well be higher for each of the groups.

COMPARISON OF SCHOOL STATUS ONE YEAR AFTER BIRTH BY SCHOOL STATUS SEVEN MONTHS AFTER BIRTH. At one year after birth, school status tends to remain the same at it had been at seven months postpartum (Table 27). The school continuation (in school or graduated) rate at one year was highest for those clients who were in school at seven months (72 percent). Similarly, the highest rate of employment or job training was for those who had been in employment or job training (56 percent); and the highest rate of school discontinuation was for those who had been dropouts (49 percent).

Table 26 School status at one year after birth by school status while pregnant in TAPP (determined "At Birth") for female followup cases 1983-1984.

1 year post partum / At Birth	In School or Graduated		Employed or Job Training		Dropout		Total	
	number	percent	number	percent	number	percent	number	percent
PMP	23	66%	4	11%	8	23%	35	100%
Other School	11	78%	2	14%	1	7%	14	100%
Dropout	4	31%	0	0%	9	69%	13	100%

BEST COPY AVAILABLE

Table 27 School status one year after birth by school status seven months after birth for female follow-up cases 1983-1984.

1 year after birth / 7 months after birth	In School or Graduated		Employed or Job Training		Dropout		Total	
	number	percent	number	percent	number	percent	number	percent
In School (but not graduated)	47	72%	6	9%	12	18%	65	100%
Employed or in Job Training	2	22%	5	56%	2	22%	9	100%
Dropout	18	46%	2	5%	19	49%	39	100%

Unknown	1	1	0	

BEST COPY AVAILABLE

COMPARISON OF DEMOGRAPHIC CHARACTERISTICS OF SCHOOL DROPOUTS AND THOSE CLIENTS IN SCHOOL. Four demographic characteristics of TAPP female clients who are school dropouts were compared with those who were still in school seven months after birth (Table 28). The two groups did not differ with respect to age distribution, living arrangements, or marriage status. However, clients in school seven months after birth were significantly more likely to be Black. Dropouts were significantly more likely to be (Non-Hispanic) White. Thus the (Non-Hispanic) Whites are more likely to be school dropouts seven months after birth. Further analysis of the characteristics of dropouts and those in school will be possible by examining dropouts at entry and at birth when computer compatibility between the TAPP Data Base and the University is achieved next year. Then the extent to which the dropouts are the same individuals at different followup times can be studied.

IMPLICATION OF RESULTS.

TAPP has low school dropout rates, even when the clients who are employed or in job training, but not graduated, are included with the school dropouts. The Pregnant Minors Program apparently is attractive to TAPP clients staying in school while pregnant, especially to those who were dropouts at entry to the program, since more pregnant teens choose to attend PMP. The clients usually attend the PMP one or two semesters until the baby is born; then they must leave the PMP at the end of the semester.

Table 28 Demograpic Characteristics of female TAPP clients by school status at seven months after birth.***

	Ages (Years)			Ethnicity			Living Arrangements			
	14	15-17	18	Black	Hispanic	White	Parents or Relatives	Spouse or Partner	Alone	
In School or Graduated N=62	(5%)	37 (60%)	22 (35%)	38 (61%)	14 (27%)	10** (12%)	43 (69%)	13 (21%)	6 (10%)	
Dropout N=33	2 (6%)	17 (52%)	14 (47%)	9 (27%)*	11 (33%)	13** (39%)	20 (61%)	11 (33%)	2 (6%)	

* Significantly different (P.05).

** Significantly different (P.05).

BEST COPY AVAILABLE

The Client Satisfaction Survey conducted in 1982-83 indicated that participants in the PMP preferred attending school there. When they have lost their eligibility (after completion of the semester in which the baby is born), they may find the barriers to re-entering the mainstream schools more difficult than those who have attended other schools during pregnancy. This would explain the trend (not statistically significant) for TAPP clients in the PMP program to have higher dropout rates 6-12 months after birth than clients in other schools during pregnancy. Implications are that special attention needs to be directed to schooling of PMP clients after the baby is born. Aims should be either to extend PMP eligibility until graduation or until the girls have obtained appropriate childcare elsewhere.

Clients who are school dropouts seven months after birth do not appear to be different from clients in school with respect to their age, living arrangements or marital status. TAPP female teens who are school dropouts at seven months after birth are disproportionately White (non-Hispanic). They do not appear to be more likely to be married, living with a partner, or older. Thus, the only apparent risk factor we have identified to date for TAPP clients dropping out of school is being non-Black and non-Hispanic. It is also clear from examination of individual records, but is impossible to show with computer capabilities, that many dropouts do not persist as dropouts; instead they often return to school and graduate at a later time.

REPEAT PREGNANCY RATES FOR FEMALE TEENS IN TAPP

PROBLEM STATEMENT

To promote the likelihood that the teens will have the chance to mature and care for themselves and their baby (if they maintained custody), it is important that repeat births do not occur to the teens.

INTERVENTION STRATEGY

TAPP uses centralized case management to see that pregnant teens in need, as well as eligible teens who have already given birth, get counseling, appropriate health and social referrals and services, and group counseling sessions to maximize spacing between births during adolescence. (See Part III - Case Management Study for additional details on program interventions).

EVALUATION METHODOLOGY

OBJECTIVE. The objective of this part of the analysis is to determine what the repeat pregnancy rates are by year after birth.

DATA AND ANALYSIS. Data was obtained from the TAPP Data Base for female teens who were due for followup in 1983-1984. They had entered TAPP while pregnant or as mothers between November 1981 and October 1984. Information for the data base was entered on cards by the case manager responsible for each teen and transferred to a microcomputer by the data base manager. As in previous sections, we received output crosstabulations enabling us to contact this section of the evaluation.

RESULTS

The repeat birth rate by one year after birth for the female TAPP clients showed that there were two births among 93 teens followed through one year after birth (2% repeat pregnancy rate). Fifty of the clients had exited or were lost to followup. While these two girls were 18 and 19 at the second birth, each of these babies was born less than one year after the previous baby and weighed less than 2500 grams.

At the second year of followup five repeat births occurred (10% repeat pregnancy rate). Forty-nine clients had been followed for two years. During this time, forty clients had exited or were lost to followup. Two of these mothers with repeat births were 20 years of age when the additional baby was born; one had graduated, the other was employed.

IMPLICATIONS OF THESE RESULTS

Early births have been shown to have a direct effect on both total number of children and on educational attainment, both of which strongly affect occupational outcomes (Moore, 1977). In terms of educational impact, each successive pregnancy increases likelihood that a teenager will drop out of school (Furstenber, 1976), as well as decreased involvement in the labor force. Several national studies have shown a repeat pregnancy rate for women who gave birth as teens ranging between 60 and 80 percent within a two-year time frame. Thus, the low repeat birth rate of 2 percent after one year and 10 percent within two years is a positive indicator of the impact of the TAPP project. While these rates reflect the experience of clients who maintain their involvement in the project, ideally an evaluation which could trace those clients lost to follow up should be conducted. It would be important to assess both the school continuation rates as well as repeat birth rates of these clients who are unable to maintain a ongoing relationship with the TAPP program.

CASE MANAGEMENT STUDY - 1983-1984

PART III

Background

From its inception, the TAPP Program design recognized the need for a unique program component which would help augment available resources within the community in the process of meeting the needs of the pregnant adolescent, her partner, and the baby. Continuous counselors or case managers were identified as an important program link in: (1) identifying and conducting outreach to targeted clients; (2) identifying appropriate services to meet client needs; (3) providing ongoing counseling; and (4) assisting the clients in selecting the most appropriate service providers from the community at large, as well as from within the TAPP network of services. The concept of case management responded to several major gaps which were evident in many urban communities faced with adolescent pregnancy as well as programs specifically aimed at ameliorating problems associated with premature parenthood. Included in this group of programmatic factors was the limited effort at developing comprehensive pregnancy and parenting programs, poor coordination of available resources within the community, and the lack of long-term followup of adolescents once they had delivered their infants.

While a variety of adolescent pregnancy programs have been developed in the U.S. over the past 15 years, few provided the comprehensive services that were mandated in the 1981 legislation enacting the Office of Adolescent Family Life Programs. Previous efforts were often categorical (e.g., oriented to special schools for pregnant teens or special pregnant teen health clinics) and lacked a coordinated approach in the delivery of care. Additionally, services were narrow in focus, primarily oriented to the needs of the prenatal and immediate postnatal period for the young woman. Consequently, the focus was very much on the young mother and her child, rather than integrating the wider network of family members and (where appropriate) her partner, all who could potentially be engaged in reinforcing programmatic objectives and messages.

The lack of a comprehensive approach also limited the variety of services which the client would receive along various service spectrums. For example, a pregnancy program emphasizing school attendance was helpful for the teen already enrolled in school, but could easily miss the adolescent who had dropped out long before the pregnancy; or the program would not focus on the period 6 to 12 months postpartum wherein many adolescents fall through the educational cracks.

While many types of social programs do exist which can benefit the pregnant adolescent through various transition points, many adolescents do not know how to navigate through the system in order to identify those services for which they qualify. Without a careful case "conductor", many adolescents would not be able to identify appropriate programs, while others would feel defeated from even attempting to receive those services which would be of greatest benefit to them. The social skills and decision making abilities modeled by the case manager would also assist the adolescent in transferring these skills to a variety of other life situations. Along with the newfound identity, the case manager can provide both long and short term followup to clients in need. This followup enables the adolescent mother to have a special advocate in identifying community resources, especially in the areas of child care, housing and employment opportunities.

While many adolescents do participate in a variety of programs located throughout the county, there are even more adolescents who are not enrolled in any separate programs. While services such as AFDC, food stamps, and housing subsidies do exist across the county, there are many adolescents who are not aware of their eligibility. While self-sufficiency is a major goal of the comprehensive pregnancy programs, most agree that there may well be a need for an adolescent to receive this support in order for her to complete her schooling, thus enabling greater self-sufficiency in the near future. Simultaneously, without an extensive case review of the types of services being utilized by the client and her family, there may be duplication or inefficiency of services utilized. The role of the case manager then becomes one of marshalling the appropriate constellation of services which best meets the needs of the client, while preventing unnecessary resource allocation. In many communities, there may not be any need for new or additional services, but rather a more effective orchestration of existing resources. Thus, the role of the case manager has been developed to close these previously identified programmatic gaps.

Case management functions in social services have been identified as being important. Yet, little empirical research exists which identifies the elements of high quality case management. Furthermore, there has been limited effort to identify whether there is a relationship between high quality case management and treatment outcomes (Ryan, 1976; Mueller and Hopp, 1983). Case management has been defined to include all phases of service delivery, from intake through diagnosis, development of a treatment plan, management of service delivery and referral, to case termination and any residual followup after termination (Ryan, 1976). Good case management implies continuity of services, planfulness (i.e., rational decision making) in designing and executing a treatment package, coordination among all providers of services, effective involvement of the client, timeliness in moving clients through the process, and maintenance of an informative and useful case record.

In some preliminary research in the area of mental health, case management has also been found to be a cost effective approach as it helps to reduce frequency and duration of rehospitalizations. Ideally, a cost benefit analysis would assess the cost effectiveness of case management in the area of adolescent pregnancy, wherein rehospitalization, as well as low birthweight, school dropout, and repeat births are significant in this population. Before this analysis can be conducted, basic questions regarding the roles and functions of case managers in the field of adolescent pregnancy must be answered.

Defining Case Manager

While there are researchers who have recently documented the case manager phenomenon in a variety of social work settings (e.g., mental health, developmentally disabled counseling services, etc.), the literature has not identified the role in agencies providing services for pregnant adolescents. (Pincus and Menahan, 1973; Bertsche and Horjsis, 1980; Cohn and DeGraaf, 1982) The success of the TAPP model during the last three years, as well as its strong emphasis on case management, raises the question as to whether case management has contributed to the program's success. Before that relationship can be established, research is necessary to identify the definitions of the tasks and responsibilities which constitute the role of case manager.

This year's evaluation examines case management quantitatively as it establishes whether there is a relationship between service units and client success, as well as qualitatively, as definitions of case management, successful and unsuccessful client interactions, and role definitions emerge from the professionals performing case management within the TAPP program.

An extensive written questionnaire examining the various parameters of case management was completed by all of the 13 staff case managers, two staff members who work closely with case managers (an employment counselor and the director of the infant nursery), and three case management supervisors, who have had previous case management experience.

The questionnaire was developed based on the Center's working knowledge of the case manager role as well as an extensive literature review of case management in various social work settings. Once items were developed, they were reviewed by the program administrators, as well as by Rick Barth, D.S.W., who is studying the effects of case management in a welfare agency and Paul Harder, Director of the Center for Human Services and Family Policy, URSA Institute, who has been responsible for developing evaluation and training designs for the Office of Adolescent

Pregnancy. The following report summarizes results from the survey. As this was a first attempt to pilot a workable questionnaire, many of the questions that were asked were open-ended, thus creating a variety of categories which could then be integrated in future efforts at studying case management in other settings. Thus, all data reported within this report reflects the opinions and reflections of the TAPP case managers.

RESULTS

Case Manager Work Characteristics

While the concept of case management has been implemented in several social service fields, it is a new concept in programs providing care for pregnant and parenting adolescents. The majority of staff members (70 percent) have not worked as case managers before their employment at TAPP. For the other staff members, their case management experiences emerged from working in diverse social agencies, including the San Francisco Boy's Home, The Battered Women's Project, The City Attorney's Office, and The Department of Social Services. The majority of case managers have been employed for 6 to 12 months, with an additional 31 percent employed less than 6 months by TAPP. Thus, many staff members are undergoing an adjustment to their role as case managers. Simultaneously, the extensive demand for TAPP services has resulted in larger caseloads than originally anticipated. Caseloads for full-time staff averaged 41 cases, while for part-time staff, the average caseload was 21. The range of caseloads is 10 (part-time staff) to 48. Seventy-seven percent spend an average of 1-3 hours per client per month. The range of meeting time is from 10 minutes to 12 hours per meeting. The group was evenly divided between those who feel that their caseload is too heavy, thus not enabling them to have enough time for each client, while the other half felt that their caseloads are "just right," enabling them to have adequate time for each client. The majority of case managers (77 percent) expressed that they could use more time to meet with their clients. Not surprisingly, there was a strong positive correlation between case managers' caseloads and their assessment of time issues.

The majority of case workers expressed thatthey were able to establish a good relationship with 75 percent of their clients, although answers (range between 20 percent and 95 percent). A good relationship was defined as one where there is good rapport between client and counselor, empathy, honesty, responsiveness, and ability to establish mutual trust. Other components of a good relationship included adequate time to provide services, a skilled case manager who knows how to identify the most appropriate services for her/his client, and one who "builds on client's strengths as a means of teaching the process of self-sufficiency." Among the factors identified as most important in facilitating good relationships with clients were the following: 1) formal and informal time spent together over an extensive period, thus providing a real relationship to be established and sustained; 2) availability of case manager for the client - both "physically," so that the counselor can join the client when seeking some social services or provide the client with some concrete service, and "psychologically-emotionally," whereby the case manager acts as an advocate and support system, accepting the client in a non-threatening manner; and 3) client's own motivation: thus, the relationship is facilitated if the client demonstrates some interest in following through on the assistance provided by the TAPP program.

When asked what the major barrier was in preventing good relationships, the majority responded that time was the most important factor. Adequate time with each client was particularly crucial in working with this population, as many clients lack self-esteem and the skills necessary to develop trusting relationships, especially with someone representing a social servcie agency. Many clients are suspicious of "helpers," especially if they had a previous social agency experience which was negative.

Cultivating relationships within a "9-5 framework" was also considered a disadvantage, as many clients can only be reached after work hours. Finally, personal factors in some situations also blocked relationships: for example, a need for great perseverance in following up patients, especially after they have broken appointments or when they cannot be reached because they lack a phone or they move without informing the case manager. Two individuals expressed that many clients are not verbal or are uncomfortable about being open with someone who does not share the same cultural values. There has been a concerted effort by TAPP management to hire staff that are comparable with the clients utilizing TAPP services. However, while there is an effort to match ethnicity between clients and case managers, caseloads sometimes prevent a complete match. Overall, it appears in spite of some limitations, that staff members are able to establish rapport with their clients.

The majority of case managers (77 percent) hold group counseling sessions, varying from family groups, held with a particular client and her/his family, to more formal support groups for pregnant teens and teen fathers. Counselors expressed that group counseling is extremely effective with these clients as they: 1) incorporate peer dynamics, including support and information; 2) decrease isolation and the sense that "only me" is experiencing this emotion; 3) create a common ground whereby information and "consciousness on issues" is established; and 4) enable group members to see a range of problems, opinions, and options available. Simultaneously, group counseling is not necessarily a panacea, as it requires extensive work in establishing and maintaining the group; does not actively involve all clients, especially those who are introverted; and many groups remain superficial, thus still requiring a great deal of individual counseling time.

Teen Fathers

The TAPP project has been extremely innovative in integrating the role of the baby's father within the framework of the program. The Teen Fatherhood Project has enabled special staff to be involved in outreach activities and in the providing of specific services, such as school and job counseling to the male. While staff have been encouraged to involve the fathers as much as possible, this effort is not always feasible, as many of their clients' do not want their baby to be involved with the father, whether or not there is currently a relationship between the child's mother and father. The average manager attempted to involve the teen father in 64 percent of all cases with a reported 35 percent success rate in establishing contact. While the success rate may appear low, several factors may be contributing to this rate. First, there is a resistance among many males to becoming involved with their child, often as a result of restrictions placed by the pregnant teen's parents. In some cases, they may not even be aware that they have fathered a child. Once male outreach workers do have an opportunity to contact the father, some of this resistance is diminished. The second major factor relates to age restrictions that the program has had to implement in the numbers of services they can provide to fathers over the age of 18. Demographic data from the 1983-1984 evaluations indicates that there is a large number of fathers who are at least two years older than the young women, thus preventing them from receiving direct services, such as employment counseling. While support groups are available, without the full range of services available through TAPP, they may not provide the most appropriate motivation for involvement by the older teen father. Male involvement, however, was perceived overall as a positive factor in the client's participation in the program and in the type of relationship established between the case manager and the client. Ninety-two percent of the staff expressed that their relationship with clients improved as a result of their outreach to the male partner. One counselor stated that through male involvement, "there was an increased interest on the part of the father, thus enhancing his ability to support and nurture the client." Sixty-nine percent expressed that this contact increased the client's participation. As a result, female clients can utilize the partner for additional, follow-up support. In other cases, the female client's awareness of the counselor's relationship with the male enables her to examine problems from multiple perspectives. The remaining 31 percent of the staff did not perceive a negative impact of male involvement, but rather a status quo situation, wherein the female client is well supported in the TAPP system whether or not a relationship has been established with the male.

When the staff were asked if they felt there was a difference in case planning for male and female clients, the answers were almost evenly divided between those who felt there was a difference (54 percent) and those feeling that there was no difference (46 percent). However, 67% felt that the approach adopted for the male has to be significantly different, even in the provision of the same services as to the female clients. Seventy-seven percent of the staff stated that sex roles dictate how each interacts with male and female clients. Males were perceived as requiring more 1) outreach, as many refuse or don't know how to ask for help; 2) concrete, tangible services specific to the immediate needs felt by males, e.g., employment counseling; and 3) specific information and ways to involve males in the pregnancy, delivery, and parenting. In spite of these role differences, both male and female counselors appear to be committed to extending all the pregnancy and child-related services to the male as well as the female clients.

Family Involvement

A series of questions were asked regarding family involvement within the program. Contact with members of the client's family is established in 83 per cent of cases with a (range from 45% - 100%). The family member most often contacted is the mother (92%): Grandmothers, brothers, sisters, and guardians each account for 23% of the staff's outreach effort. Other family members include both parents, father, step-parent, aunt, and father of the baby. (Answers add up to more than 100% due to multiple responses.)

Family involvement was perceived as positive almost all of the time by each staff member because the period of pregnancy is not only tumultuous for the teen, but for her family as well. Thus, the case manager can be effective in opening lines of communication.

One staff member explained that this contact enabled the client's mother to express her feelings towards the pregnancy; and eventually, the mother was able to feel more at ease and supportive. This expression and resolution of guilt, anger, fear, and frustration was especially helpful for family dynamics. Beyond helping the parent come to terms with the pregnancy, family involvement succeeded in accomplishing two other important goals: (1) It further cemented the relationship between client and case manager as it demonstrated a sincere interest in the total life picture of the young woman; and (2) The parents and the case manager became more of a team, as parent involvement meant more support for mutual goals. Thus the case manager can rely in part on the parent in assuring that the client is following through with the referrals and other program components. This parental role is viewed with caution as the parent may not always be consistent and thus "can't provide follow-through nor appropriate parenting themselves." In some situations, the parents call the case manager when they feel they need help for themselves or feel concerned about some specific issues. In about 15 percent of all cases the mother-daughter relationship is chaotic; and family involvement assisted the client in establishing the necessary ways for dealing more effectively with the home situation.

The case managers expressed that they felt there was more consistency and more effective monitoring if the parent is also involved, although we were unable to assess from this survey whether this participation is greater than for those clients whose parents are not involved. Since most parents are attentive to their responsibilities, they facilitate the case manager's role in ensuring that clients call the case manager in their presence. Case managers feel that it is easier to get in touch with their clients, and that mothers will pass along messages effectively and have the clients call back the case manager. Thus, with parental participation, there is more support for the case manager's role.

Parental involvement appears to be an even more important component of client interaction with the TAPP program, while male involvement appears to be more beneficial in a less direct manner. Both family and male involvement do appear to be important in the success of the program and in the reinforcement of information provided by the case manager.

Role of Case Manager

The case managers were asked a variety of questions related to their perceptions of the roles and activities encompassed within their jobs. When asked to identify their major activities, four categories emerged from the respondents. Counseling, both narrowly and broadly defined, was the major activity identified by all 13 respondents. From one-on-one counseling, family mediation, and group work, as well as counseling regarding the seeking of needed social services, this activity was a top priority. Ninety-two percent of the sample identified agency networking and referral as their second major type of activity. Specific aspects of this role included the identification of services, case consultation, assisting the client in navigating the system to receive concrete services, and acting as a liaison with the broader community of social services. Another major category could be characterized as providing "other" direct services. A variety of activities were listed, including conducting case conferences involving various agencies; planning groups; monitoring client's progress through case plans, including necessary documentation; and conducting home, school, and social agency visits with their clients. A final major category reflected the special friendship relationship which emerged between case manager and client. Advocacy, along with this friendship, was identified by 62 percent of those surveyed. Specific activities included special outreach to special populations, acting as an advocate to ensure that clients attain services, and follow-up to assess that clients in fact are receiving needed services. Finally, their role in building self-determination and motivating clients to realize their potential was expressed by nearly half the respondents.

Case managers were also asked to assess the necessary qualities for a successful case manager. Each respondent was asked to expound on several professional components and then to rank the components in order of their importance to them on a scale of one to five, with five indicating the most important quality. The following table summarizes these rankings.

Table 1

Case Manager Qualities As Ranked By TAPP Staff

Life Experiences	3.73
Professional Experience	3.47
Education	3.13
Knowledge, Skills	2.73
Personal Qualities	2.27

The TAPP staff attached almost parallel qualities to the "life experiences" and "professional experience" of the "ideal" case manager. Within "life experiences," 54 percent of the staff supported the need for the individual to have experienced a broad variety of situations, in which they were able to gain insights and develop sensitivity to adolescents, various cultures, ethnicity, and the cycle of poverty. In turn the case manager needs to know how to draw from these insights in dealing with her/his clients. The second most often cited need (46 percent) related to the experience of children, either directly, as a parent, or more indirectly, with the experience of a pregnancy within the immediate family.

The most important professional experience cited by the staff pertained to previous work experience with adolescents (62 percent). The ability to work in a non-judgemental manner with young people was considered far more important than previous experience with case management, which was only cited by 38 percent of the staff. Other professional experiences listed included working with diverse cultural groups and clients of low economic background.

Responses to the question of education varied. Thirty-eight percent of the group expressed that education in the areas of child and adolescent development, cultural and ethnic issues, and human psychology were of paramount importance. Only one case manager argued for a master's degree, while two staff members felt that a bachelor's degree is adequate, for an advanced degree does not necessarily assure ease in dealing with clients.

The types of knowledge and skills most often mentioned by the staff could be categorized in the following manner: 1) Counseling/communication skills - 69 percent; 2) Knowledge about adolescents and how to deal with them effectively - 54 percent; 3) Knowledge of community resources - 38 percent; 4) Knowledge in the area of pregnancy/labor/delivery and birth control - 31 percent; 5) Inter- and intra-organizational skills - 23 percent. These figures equal more than one hundred percent, as multiple skills were mentioned by many staff members.

A long list of personal qualities was offered by staff members to define the necessary attributes of a good case manager. While "Personal Qualities" was ranked lowest by the staff, it is apparent that without these personal attributes, the case manager cannot be expected to be truly successful. The following is a list of terms utilized by the staff: empathy, compassion, patience, inner strength, flexible, persistent, faith in the client, ability to relate to teens of different cultural backgrounds, ability to balance relationships, sincerity, resourceful and self-confident. They reflect a sense that one needs a highly personable individual to be engaged in this role.

The role of case manager can vary from the social service system side (e.g., beinç a "broker of services") to the personal side (e.g., providing direct counseling services). As part of their questionnaire, TAPP staff were asked to assess the mix of services they provide. The following table summarizes the results of this service broker/personal side mix.

Table 2

Role of Case Manager:
TAPP Staff Ratio of Services Provided

Personal Counselor/Service Broker	Number of Staff	Percentage
30%/70%	1	8%
40%/60%	2	15%
50%/50%	2	15%
70%/30%	5	39%
80%/20%	2	15%
100%/0%	1	8%
	13	100%

As shown in Table 2, the majority (62%) of counselors assessed their roles as more heavily oriented to direct counseling than to broker; 23% felt their role to be more oriented to broker than to counselor; and 15% felt their role was evenly divided between the two activities.

As counseling is such an important task, the staff were asked to assess how their role differs from other social service providers. Seventy percent of the group identified the case manager as playing a unique role in providing a wide range of services for their clients over an extensive period. The time element thus enables the case manager to provide a continuously changing set of services as their clients' needs evolve. As one case manager stated, "One must be concerned with the client's total needs (i.e., health/medical, educational, familial, social, child care, housing, etc.). We assist with the management of that person's needs to help make the client's existence as complete as it is possible with regard to all factors, i.e., economic, environment, etc." The long-term relationship was explained in the following manner: "A case manager is a semi-permanent guiding reference for a client; a case manager is like being a North Star." The variety of tasks which the case manager must juggle and the variety of direct (e.g., counseling) and indirect services (e.g., referrals) they provide is reflected in the following comment: "As I see it, the case manager is a Jack or Jackie of all trades. They must assist in all life skill areas." An additional 15% expressed that the extensive period of time in which they are involved with their client also provides a unique opportunity for extensive follow-up and enables the case manager to assess whether the client is receiving all needed services, either directly through TAPP or another agency(s). Two counselors expressed somewhat different perceptions. One commented that the case manager's role is more limited to keeping extensive case notes, as well as "filling out a hundred forms for necessary services." One other counselor expressed frustration at being forced to limit the amount of clinical counseling, when their job required the providing of more concrete services, such as day care, housing, and assessing school status. These opinions were a sharp contrast to the majority opinion that there was a clear advantage in being able to handle all aspects of a case, including counseling, information and referral, agency networking, and case conferences regarding a particular client and her/his family.

Case managers were provided with a list of twelve tasks and asked to rate how often they have the opportunity to perform the task, how often this occurred as part of their jobs, and whether they were trained to perform this task. Table 3 summarizes this information.

Table 3

Case Managers' Major Tasks By Frequency

Task Category	Occurrence				Trained to perform this task?	
	Rarely	Sometimes	Most of the time	Always	Yes	No
Record Keeping	---	---	23%	77%	69%	31%
Case Planning	---	15%	23%	62%	54%	46%
Counseling Clients Individually	---	---	62%	38%	54%	46%
Information and Referral	---	23%	38%	38%	69%	31%
Follow-up	8%	8%	46%	38%	69%	31%
Attending Case Conferences	15%	31%	31%	23%	54%	46%
Outreach to Service Providers	---	54%	23%	23%	38%	62%
Counseling Clients' Families and Partners	---	62%	31%	7%	46%	54%
Attending Other Meetings	---	38%	54%	8%	69%	31%

This table identifies the nine job components rated most important, both as a function of the opportunity to perform the task and how often it occurs. Two other activities were mentioned as important, but these had larger percentages of "rare" rankings. These "rare" activities include outreach to potential clients and providing health education. For both of these activities there was a general sense that there was no time available to do these additional components. Both these tasks received the largest percentage of no training to perform these tasks. Health education may be assured to take place in other settings and consequently the case manager may perceive that they need to focus on other pressing needs. Yet, there appears a natural opportunity for health education reinforcement if there was working knowledge of what health education messages the clients do receive outside of TAPP. It may be important to assess the case manager's perception of health education, as this activity could already be taking place but not adequately labeled. Judgements on whether they were trained to perform this task were somewhat incongruent with how often case managers actually do engage in the activities. Consequently, this question may have been perceived as assessing whether TAPP offered the training in this particular task, rather than whether they had received specific training in this role task at some point in their professional training.

Of the aforementioned list, the three most important tasks were identified as 1) counseling clients; 2) case planning individually; and 3) information referral. The two least important tasks were 1) attending other meetings and 2) health education. These selections indicate the reality of conducting case management within an agency, as well as the perception that health education is provided by others and that their time is better spent in providing adequate referrals and information.

Other aspects which are considered essential for the implementation of effective case management were 1) good relationships with other service providers (30 percent); 2) adequate time to perform all case management tasks (23%); and 3) effective organizational management and positive interpersonal support among co-workers (23%). The rest of the answers were miscellaneous, but included the following role aspects: need for psychotherapy time with clients, ability to train clients in "motivational training" and personal financial planning education, adequate services available, such as housing and day care, and ability to communicate effectively and get along with other people.

Problems in Implementing Case Management Role

The most important problem experienced by the staff in implementing case managers ment was identified as having inadequate time to provide each of the case management roles. Seventy-seven percent expressed that they were limited both because of the heavy caseload they carried and because of the demand to be comprehensive in the types of services they provide. Counselors expressed a desire to be providing a greater degree of direct counseling, as compared to the multiple other services they provide. Thus, if their one-on-one time is limited, what tends to be diminished is the clinical counseling component. This conflict appears to be felt strongly by two groups: those who have had limited experience as a case manager, and secondly, those who have caseloads over 35. Thus, the extensive demands on the counselor to coordinate a myriad of social services often limits the time available for the more in-depth counseling case managers perceive to be important. Another 23 percent expressed that the needs of their clients and the variety of services channeled through the counselor often require the counselor to work flexible hours. Current work hours were perceived by some to limit their availability and accessibility for some clients. An additional 23 percent expressed that some of the clients themselves were resistant to the case managers, either by only seeing them at time of crisis or by their lack of interest in receiving a comprehensive package of services that is required by the program. Another 31 percent of the staff expressed difficulties with appropriate time management and the need to learn how to balance the time spent on each case in each activity. An additional 15 percent perceived paperwork and data collection as being a negative activity, particularly as it takes time away from client time. (Note: Answers equal more than 100 percent, as multiple reasons were given by several staff.) In summary, it appears that staff are primarily concerned with the demands of time and large caseloads interfering with their primary role as counselor. While case management is an effort to balance counseling with a broker-of-services concept, staff members would rather provide more direct counseling services.

When the staff was asked to identify potential solutions, the majority (54 percent) expressed an interest in dropping the maximum caseload to between 25-30 and to add additional staff members to enable case managers to carry a more reasonable load. Two specific suggestions were also insightful. One requested that categories of cases - i.e., active, inactive, monitor only - be more clearly delineated, thus enabling the case manager to have a balance between time-demanding cases and others. A second suggestion was to assign staff to work more in their area of interest or expertise. While there is an effort to assign cases by certain factors, such as cultural appropriateness, case assignments are often based on the current caseload of the staff. This suggestion appears to promote a match between those counselors who desire to provide more clinical counseling with those clients in greater need of this component. Thus, these case managers may need a different balance of cases to make their roles more effective. Fifteen percent expressed that less paperwork or a more efficient system (e.g., dictaphone and secretary or computerized case files) should be implemented. Thirty-one percent requested additional training in time management and supervision which would impact on the manner in which staff shares talents and skills with one another. Miscellaneous suggestions included flextime and an effort to work even further in coordinating efforts with other community agencies.

Case Manager and Client Interactions

When asked to identify services that are difficult to obtain for their clients, the most often cited were child care (77 percent), housing (46 percent) and employment (31 percent). Other miscellaneous services identified were respite care, financial planning, counseling and mental health referrals, AFDC, and counseling for domestic violence. One individual felt that all services were difficult to obtain for their clients. When asked what their response is in this situation, 62 percent expressed that they actively pursued services for their clients until they were able to find some type of service. As one case manager eloquently stated, "I make lots of calls to people or places who might have information or knowledge of other resources available that I don't know about. That's exactly what makes a good case manager. I search and persist until I find something for my client and I'm not afraid to use the phone to ask." Thirty-eight percent expressed that they did not involve themselves in locating new providers primarily because they feel they have no time to be explorative, particularly when it would take away from other commitments. For this sample, it appears once again that caseload hampers the implementation of the best aspects of case management.

The staff was also asked about the services which their clients are reluctant to accept. All case managers felt that there is a variety of services that clients were resistant about using. The service most often mentioned was public health nurses (31 percent), followed by birth control services (15 percent) and school continuation (15 percent). Miscellaneous other services included family visits, adoption, day care, group counseling, mental health counseling, and unpaid training programs. Counselors mentioned that men were resistant to one-on-one counseling, acceptance of medical assistance, and afraid of counseling referrals to other agencies. The wide range of services mentioned in this list reinforces the value in establishing case management services for this population, for without their support, assistance, and follow-up on whether clients actually pursued the services, many of these clients would be lost within the system. This vital role of case management is reflected in the answers provided by the staff when they were asked how they deal with client hesitation. Seventy-seven percent of the counselors provided answers which could be categorized as making these service options viable, while still enabling the client to make the final choice. Within this category, 30 percent of the counselors played an assertive role, including having the teen actually meet the service provider so that they can explain services, assisting in setting up initial appointments so that the client tries out the service, and following up with the client to see whether they have tried the service. In several answers, case managers explained that they would mediate with the client and potential service provider. For example, the case manager may have the client meet the public health nurse in a neutral location, rather than in the person's home. Another strategy is the involvement of parents and partners in exploring the pros and cons of a certain behavior. Patience in the decision-making process was also mentioned as an important factor, as many of the clients need time before they feel ready to accept the suggested service. There was wide agreement among the group in the sense that no one can force the client to accept a service, and that the client needs to be worked with in a careful manner in order to gain acceptance. The remaining miscellaneous answers included the need to refer clients to teen oriented services that have special sensitivity to their needs and the seeking of assistance from the case manager's supervisor for decisions on transfer or closure. Overall, the answers demonstrated a high degree of persistence in helping clients match with the variety of services that they need.

Client Needs

The transitory nature of many of the clients' lives requires case managers to keep themselves extremely informed regarding the status of their clients. When asked to identify the systems they use, each of the case managers responded that they rely on a close relationship with clients and effective networking with agencies providing services to their clients. The case managers maintain either phone or home visit contact a minimum of twice a month and, for very high-risk patients, weekly contacts. Besides relying on the clients, the case manager often communicates with those service providers who are directly involved with their clients (e.g., child care staff, school personnel, medical staff). In some cases, information may come from the clients.

The case managers were also asked how they maintain track of the services received by their clients. The most commonly used system was the case management form (62 percent), with case notes, client roster sheet, service provider follow-up records, and asking service providers directly each receiving 15 percent of the answers. Other answers included summary contact form, medical notes at clinic, and asking clients directly. One respondent expressed that keeping track is facilitated by the fact that most of the services have been arranged for by the case manager, and that the regular checking-in with the client almost guarantees that the case manager will be made aware of new services, changes, etc. Thus, from this extensive list, it appears that case managers utilize a variety of record-keeping mechanisms to keep track of the services received by their clients.

One of the main purposes of this survey was to identify the types of strategies utilized by case managers and to gauge how often these strategies are utilized in their work. The following table summarizes the most important of these strategies, listed in order of frequency.

Table 4

Case Management Strategies and Their Occurrence

Task Name	How Often Utilized		
	Use With Most Patients	Use With A Few Clients	Almost Never Used
1. Calling to set up appointment with the client in the office	69%	31%	---
2. Having client call to set up appointment while case manager is present	62%	31%	7%
3. Home visit or telephone calls with clients	46%	---	---
4. Visiting the agency with client to ensure that a client attends	39%	61%	---
5. Check with client's partner or parent to see if task is completed	39%	8%	---
6. Having a client attend the service with a friend	7%	54%	39%

NOTE: Multiple answers given by each staff member.

Additional strategies case managers reported as using with most of their clients included: 1) Follow up with agency to see if client showed up; 2) Case conference at neutral site; and 3) Meet client at her primary site or at some other community site (each 15 percent). Three other strategies were each used by 8 per cent of the staff with most clients. These include 1) role playing before client performs task; 2) having clients write notes and diaries on paper; and 3) having client call the staff back after completing the task.

The wide variety of strategies attests to the strength of the case management staff at TAPP. The two most commonly used strategies (e.g., calling to set up appointments with the client in the office and having client call to set up appointment while case manager is present) reflect philosophical positions as well as varying needs and decision-making capabilities among different clients. One of the most important roles of the case manager is to assist the clients in gaining self-sufficiency skills, thus empowering them to "navigate" through the social system maze. While a certain amount of "hand-holding" is necessary (particularly with younger clients and those whose primary language is not english), case managers recognize that beyond the positive modeling they can offer the client, the client needs to take some initiative. Thus, clients practice system "survial" skills in order to transfer those capabilities to other situations in their life, especially when the case manager isn't present. The delicate balance necessary to achieve an appropriate facilitator role is very much dependent on the client and the interaction that occurs between the two. Thus, it is imperative that case managers have a variety of strategies which promote their client's self-reliance.

When asked to describe the major successes they have encountered in relation to their clients, case managers perceived that seeing their clients achieve healthy pregnancies, stay in school, and improve their family interpersonal relationships were the most significant (62 percent). A second major category, with 54 percent of responses, consisted of facilitating their clients' personal growth and improvements in their clients' self-esteem. As one case manager stated, "I have helped them through difficult periods, been a friend and supporter at a time when no one else would get behind them. It's temporary but critical." This awareness that they have helped their clients grow and learn from their experiences, and empowered them to become responsible people, is particularly gratifying.

Case managers were also asked about the problems they encountered in relation to their clients. The most important problems (46 percent) were associated with client resistance to the case manager - either overtly, as a result of their fears of being "victimized" by yet another system, or more indirectly, in problems associated with following up clients with an endless series of disconnected telephone lines. Some clients are resistant to help and are reluctant to accept another person, especially if that person has not experienced being in this situation. Another set of problems, mentioned by 31 percent of the staff, related to difficulties in establishing trusting relationships. One case manager summarized both the relationship and resistance problems in the following manner: "As a case manager who has just recently entered the lives of these kids, relationships are particularly vulnerable. Often these kids have had lives which have been so messed up that the little band-aid kinds of help I can provide may make little difference. Other kids you can reach, but more of a mental health perspective needs to be included in our work."

A final set of problems was associated with the inabilitv of the clients to follow through with the services provided through TAPP directly or by referral (31 percent). Getting the clients to follow through with plans so that they don't lose out on a child care slot or on getting back into the school of their choice were given as examples. The consistency necessary to meet appointments may be particularly difficult for clients who have had a lifelong pattern of "no connectedness." Other problem areas cited included lack of adequate job or employment opportunities, uncooperative parents, and the case manager's inability to be in two places at the same time.

Case managers were also asked to state what the most critical decisions are that they made in their jobs. Two major categories emerged from their answers: decisions on how they will personally handle a situation (62 percent) and child abuse and neglect (38 percent). Within the category of personal decisions, case managers face the need to 1) avoid making pre-judgements on how a young woman faces her situation; 2) decide whether or not to make a decision for a youth; 3) develop strategies for establishing support with clients having different personalities; and 4) decide where the fine line is between "advocacy and being too pushy." Thus, knowing when to "back off and leave the client to accept consequences" is particularly challenging to the individual case manager.

The second most important decisions related to the treatment of the infant. Answers included the need to be involved if the removing of a child from his or her home is necessitated, reporting child abuse and neglect, as well as deciding whether or not a parent is fit to be a parent. This topic area also included concern for sharing medical information in the most effective manner so as to prevent child abuse. Both the decision areas again lend support for the ongoing relationship role the case manager provides, not only to the client, but to the infant as well.

The case managers were asked what they would do if they were asked to develop a case management project from scratch, based on their experience with TAPP. The major revision proposed by the staff is to put a reasonable ceiling on the caseload for each staff member. Thus, a maximum caseload of 25-30 is perceived as ideal. This caseload enables one to see clients more often and develop a more trusting relationship. Secondly, there is extensive need for a highly competent professional staff, who also have the opportunity for ongoing clinical supervision and ongoing training in case management. Thirdly, there is a desire for more time flexibility in performing all the various aspects of the case manager role. In addition, data management must continue to be effective, but greatly simplified. Finally, there appears to be a need to build in different opportunities for sharing of commonly known resources, as well as staff and management support of staff facing a very challenging caseload. Thus, burn-out commonly experienced in the social service system needs to be dealt with in a preventative manner. Limiting caseload size, thus enabling more in-depth,personal and trusting relationships to develop, is perceived as one viable alternative. While small caseloads may not be perceived as cost-effective, it is felt that they will be in both the long and short run as case managers feel they can have a greater impact on their high-risk populations.

CONCLUSION

In summary, the Case Management Study, has provided in-depth information concerning the importance of program links between services provided for pregnant and parenting adolescents and treatment outcomes.

While a comprehensive service approach is recognized and generally accepted as imperative in dealing with the myriad of problems facing pregnant and parenting adolescents, the role of an astute case manager in assuring that in fact services are being utilized has received limited attention. Thus, this study has aimed to clearly define the roles, skills and functions of the case manager. The special needs of the adolescent clients necessitates an effective navigator/big sister or big brother role - guiding the client through the system so that they may receive appropriate services, whether they be housing medical care, employment, school or child care. Beyond the match making function lies an even more important task - that of follow up and orchestration of services. Thus, it is important not only to identify (or help the adolescent find) the services that they need, but to also assure that there is continuity and consistency in the utilization of these services, whether they be short or long term in nature.

The Case Manager's impact clearly goes beyond the effectiveness of an ongoing relationship with a client (and his/her family) in meeting his/her particular needs. In their capacity, they become a cost-effecient resource for their communities, assuring that available resources are used effectively, avoiding misuse and duplication of services.

Standards of care, quality of care and continuity of services all rely on organization, qualifications of staff, proper information and manageable workload distribution.

During the past three years, the TAPP project has been shown to be successful in improving birth outcomes, in decreasing the numbers of repeat births, and in increasing the numbers of young adolescents who continue their schooling. Much of this success is attributed to the case manager's role, the networking among social and medical services, as well as the comprehensive service focus of the program. While the case management role in the social work setting (e.g., mental health, developmentally, disabled, etc.) has been well documented, the TAPP project is a pioneer in demonstrating the applicability of this concept in working with pregnant and parenting adolescents. It is important to recognize that in order for the case manager's role to be effective, that an appropriate balance is needed both in terms of case load size, as well as their role functions as counselors and brokers. Thus, the client advocacy and personal counseling which their clients need must be reconciled with other demands, such as documentation and agency networking. Group sessions, as well as individual counseling sessions, led by case managers are also important opportunities to deal with their client's sense of isolation and as a way to deal with peer pressure.

A strong case manager was seen to have 1) knowledge and skills, which could be developed academically or from life experiences; 2) cross-cultural training; 3) awareness of community resources and 4) strong sensitivity to client needs.

Many of the case managers expressed a sense that their academic training had not actually prepared them for the myriad of roles that they fulfill as case managers. In some cases, their own sense of identity as a clinical counselor added to a sense of personal frustration. Thus, it appears that as there is an increased need for the wide adoption of a case management role in agencies providing care in a variety of settings, that there will be additional training needs within professional schools. While it is difficult to isolate the role of case manager, as the contributing factor to TAPP's success, its integral role challenges us to further assess its relationship to successful outcomes in programs serving this particular population.

REFERENCES

Baldwin, W., Cain, v. "The Children of Teenage Parents," Family Planning Perspectives, 1980, 12:34-43.

Bertsche, A. and Horjsis, S., "Coordination of Client Services," Social Work, 1980, 25, 94-98.

Center for Population and Reproductive Health, Evaluation of the Teenage Pregnancy and Parent Project, Family Service Agency of San Francisco, October 1, 1982 and September 30, 1983, Unpublished Report, March, 1984 University of California San Francisco.

Cohn, A. and DeGraaf, B., "Assessing Case Management in the Child Abuse Field," Journal of Social Service Research, 1982, 5(1-2), 29-43.

Dougherty, C.R.S. and Jones, A.D., "The Determinants of Birth Weight," AM. J. Obstetrics Gynecology, 1982, 144: 190-200.

Eisner, V., Brazie, JV, Pratt, MW, and Hexter, AC, "The Risk of Low Birthweight," American Journal of Public Health, 1979, 69: 887-893.

Furstenberg, F. Jr., "The Social Consequences of teenage parenthood," Family Planning Perspective, 1976, 8(4), 148-166.

Jekel, JF, Harrison, JT, Bancroft, D.R.E., et al. "A Comparison of the Health of Index and Subsequent Babies Born to School Aged Mothers," American Journal of Public Health, 1975, 65: 370-374.

Lawrence, R.A., Merritt, TA, "Infant of Adolescent Mothers: Perinatal, Neonatal, and Infancy outcome, "Seminars in Perinatology, 1981, 5:19-32.

McAnarney, E.R., Thiede, H.A., "Adolescent Pregnancy and Childbearing: What we have learned in a decade and what remains to be learned," Seminars in Perinatology, 1981, 5:91-103.

Moore, K.A., Caldwell, S.B., and Waite, C.J., "Early childbearing and educational attainment," Family Planning Perspective, 1979, 9(1), 220-225.

Mueller, J. and Hopp, M., "A Demonstration of the Cost Benefits of Case Management Services for Discharged Mental Patients," Psychiatric Quarterly, 1983, 55(1), 17-24.

National Center for Health Statistics. Advance report, final natality statistics, 1977. Monthly Vital Statistics Report, 1979, 27(11).

Pincus, A. and Menahan, A., Social Work Practice: Model and Method, Itasca, Ill: F.E. Peacock Publishers, 1973.

Ryan, R., "Case Manager Function in the Delivery of Social Services," in B. Ross and S.K. Khinduka, eds. Social Work in Practice, Washington D.C. National Association of Social Workers, 1976, pp. 229-240.

Showstack, JA, Budetti, PP, and Minkler, D., "Factors Associated with Birthweight: An Exploration of the Roles of Prenatal Care and Length of Gestation," American Journal of Public Health, 1984, 74:1003-1008.

APPENDIX

Are client's parents aware of pregnancy? ☐ Yes, ☐ No, ☐ Unknown
Are partner's parents aware of pregnancy? ☐ Yes, ☐ No, ☐ Unknown

Intake
Time:___:___

Pregnant: ☐
Mother/Not Pregnant: ☐
Other Female Teen: ☐
Expectant Father: ☐
Father: ☐
I & R Only: ☐

T.A.P.P.

INTAKE FORM

Date:
Intake By:
Case Manager:
Census Tract:
Health District:
SFGH B#:

Revised: 8/27/84

Client's Name:______ Mailing List: ☐ Yes, ☐ No
Address:______ Zip:______ Phone:______
Referred by:______ Agency:______ Phone:______
Address:______ Zip:______ Reason:______
Person Spoken to at Intake: ☐ Client, ☐ Referral Source, ☐ Other:______
Intake Place: ☐ Phone, ☐ Office, ☐ Clinic, ☐ Other:______
Parent or Guardian Name:______ Mailing List: ☐ Yes, ☐ No
Address:______ Zip:______ Phone:______
Emergency Contact:______ Relationship:______
Address:______ Zip:______ Phone:______
Age:____ DOB:___/___/___ Language:______ Monolingual: ☐ Yes, ☐ No
Place of Birth:______
Race: ☐ Black, ☐ White, ☐ Amer. Indian, ☐ Chinese, ☐ Japanese, ☐ Filipino
☐ SE Asian, spec:______ ☐ Other, spec:______
Hispanic Origin: ☐ Not Hispanic, ☐ Mexican, ☐ Chicana, ☐ Other Hispanic
Marital Status: ☐ Single, ☐ Married, ☐ Divorced, ☐ Separated, ☐ Widowed
EDC:___/___/___ Previous Pregnancies: ☐ 0, ☐ 1, ☐ 2+, Explain:______
Child's Name:______ DOB:__/__/__ Sex:___ Lives w/:______
Child Care:______ None ☐ Paternity Estab.: ☐ Yes, ☐ No
Child's Name:______ DOB:__/__/__ Sex:___ Lives w/:______
Child Care:______ None ☐ Paternity Estab.: ☐ Yes, ☐ No

Client's Name:__________________________

Living Arrangements: ☐ Alone, ☐ Spouse, ☐ O Male, ☐ O Female, ☐ Parents,

☐ O Relative, ☐ Foster Home, ☐ Other:____________ Total # in Household:___

Name:______________________________ Relationship:________________ Age:___

Name:______________________________ Relationship:________________ Age:___

Name:______________________________ Relationship:________________ Age:___

Name:______________________________ Relationship:________________ Age:___

Name:______________________________ Relationship:________________ Age:___

Name:______________________________ Relationship:________________ Age:___

Name:______________________________ Relationship:________________ Age:___

☐ Additional household members (please list on back)

School Status at Intake: ☐ Attending, ☐ Graduated/GED, ☐ Dropped Out

School:____ Grade:_____

Length of time out of school:_____months/_____weeks

Reason for Dropping Out:____

Special Ed.: ☐ No, ☐ Yes, Type:________________ ☐ Unknown

School Status at Conception: ☐ In, ☐ Grad, ☐ Dropped; # weeks out:______

RECEIVING:	Yes	No	Need	RECEIVING:	Yes	No	Need
Medi-Cal:	☐	☐	☐	SSI:	☐	☐	☐
Baby Only:	☐	☐	☐	WIC:	☐	☐	☐
AFDC (payee):	☐	☐	☐	Food Stamps:	☐	☐	☐
AFDC (in grant):	☐	☐	☐	Food Supplement:	☐	☐	☐
AFDC (no payee):	☐	☐	☐	Other:_________	☐	☐	☐

Employed: ☐ Yes, ☐ No, ☐ -20 hrs, ☐ +20 hrs, ☐ LFW, ☐ Unknown

Where:__________________________ Career Goal:_____________________

Dependency/Probation Status: ☐ 300, ☐ 601, ☐ 602, ☐ None, ☐ Unknown

Other Parent:______________________ Age:_____ Mailing List: ☐ Yes, ☐ No

Address:______________________________ Zip:________ Phone:__________

TAPP Client: ☐ No, ☐ Yes, CC:________________ ☐ Unknown

Race:_______________________ Hispanic Origin:_______________________

Place of Birth:____________ Language:___________ Monolingual: ☐ Yes, ☐ No

Employed: ☐ Yes, ☐ No, ☐ -20 hrs, ☐ +20 hrs, ☐ LFW, ☐ Unknown

☐ Receiving Medi-Cal, ☐ Receiving Welfare, ☐ payee, ☐ in grant, ☐ nn payee

Specify Type(s):______________________ ☐ Not Receiving Medi-Cal/Welfare

School Status: ☐ In, ☐ Graduated, ☐ Dropped Out, ☐ Unknown

Grade:_____ School:______________ Time Out of School:____months/____weeks

Living Arrangements: ☐ Alone, ☐ Spouse, ☐ O Male, ☐ O Female, ☐ Parents

☐ O Relative, ☐ Foster Home, ☐ Other:______________

Paternity Established: ☐ Yes, ☐ No, ☐ Unknown

(Pregnant Only) Number of prenatal health care visits prior to Intake:____

(Pregnant Only) Date of first prenatal health care visit:____/____/____

(Pregnant Only) Hospital for Delivery:______________________________

Health Care Providers' Name:_____________________________________

Health Care Site:

☐ Children's Hospital

☐ Health Center #3

☐ Health Center #4

☐ Kaiser Hospital

☐ Mt. Zion Hospital

☐ Potrero Hill Health Center

☐ Private Physician

☐ SFGH Family Health Center

☐ SFGH Teen OB Clinic

☐ SFGH Women's Clinic

☐ South East Health Center

☐ South of Market Health Center

☐ U.C. Medical Center

☐ Valencia Women's Clinic

☐ Other, Specify:_______________________________________

Pediatrician Name:__________________ Pediatric Site:________________

Referrals Made at Intake:____

Psychosocial Risk Status: ☐ High, ☐ Low, ☐ Unknown

If I & R, State Why:__________151_____ # I & R Units received:________

Comments (use back if necessary): 3

☐ Perinatal, ☐ C/1 Cards, ☐ Computer

Revised: 3/25/85

TEENAGE PREGNANCY AND PARENTING PROJECT (TAPP)

PREGNANCY OUTCOME FORM

C.C.:__________

Date:___/___/___

(If Pregnancy Outcome Form has been completed for female partner, fill in only * items for male client)

* Client's Name:____________________ *Entry Date:___/___/___

* Infant's Name:____________________ *DOB:___/___/___

Prenatal Care Site:__________ *Marital Status:__________

Hospital Involved:__________ Pediatric Care:__________

* Client's Age at Conception:____ Weeks of Gestation:____ SFGH B#:________

* Parity (number of children born alive prior to this pregnancy):____

* Gravidity (number of pregnancies prior to this pregnancy):____

* Paternity established by DA: ☐ Yes, ☐ No *Client's Current Age:______

* **PREGNANCY OUTCOME:** (check all that apply)

☐ Live Birth

☐ Fetal Death
  ☐ Less than 20 weeks ☐ Induced
  ☐ 20 weeks or more ☐ Spontaneous

☐ Neonatal Death

☐ Maternal Death
Cause:________________

PRENATAL HEALTH CARE: Trimester during which client entered prenatal care:

☐ First, ☐ Second, ☐ Third, ☐ Unknown Number of Visits:________

INFANT STATUS - LIVE BIRTHS ONLY:

Sex:___ Birthweight:___lbs.___ozs. / _____grams Apgar/5 Score:______

INFANT TO LIVE WITH: (check all that apply)

☐ Mother

☐ Father

☐ Grandparents

☐ Other Relative

☐ Adoption

☐ Other:________________

* **SCHOOL STATUS:** Special Ed.: ☐ No, ☐ Yes, Type:__________ ☐ Unknown

☐ In, ☐ Grad, ☐ Dropped, Grade:____ Date:__/__/__ School:__________

School Status at Conception: ☐ In, ☐ Grad, ☐ Dropped

* **DEPENDENCY/PROBATION STATUS:** ☐ 300, ☐ 601, ☐ 602, ☐ None, ☐ Unknown

SMOKING: ☐ No, ☐ Quit during 1st trimester, ☐ Yes, # packs/day:_____

NUTRITION: ☐ Breast, ☐ Bottle

☐ Enrolled in WIC/1st trimester ☐ Enrolled in WIC/3rd trimester

☐ Enrolled in WIC/2nd trimester ☐ Not enrolled in WIC

* **EMPLOYMENT:** ☐ Yes, ☐ No, ☐ -20 hrs., ☐ +20 hrs., ☐ LFW

* **CLIENT RECEIVING:**	Yes	No	**RECEIVING:**	Yes	No
Medi-Cal:	☐	☐	SSI:	☐	☐
AFDC (payee):	☐	☐	Food Stamps:	☐	☐
AFDC (in grant):	☐	☐	Food Supplement:	☐	☐
AFDC (nn payee):	☐	☐	Other:__________	☐	☐

PAYMENT SOURCES FOR PRENATAL CARE: (1,2,3 - Greatest to Least Contributor)

☐ State MCH ☐ Title XIX (Medi-Cal)

☐ County ☐ Insurance

☐ Cash ☐ Other:________________________

WHERE DELIVERED: ☐ Hospital, ☐ Home Birth, ☐ Enroute to Hospital

TYPE OF DELIVERY: ☐ Vaginal, ☐ Caesarian Section, ☐ Unknown

CONGENITAL MALFORMATION: ☐ None, ☐ Major, ☐ Minor, ☐ Unknown

BIRTH INJURY TO INFANT: ____

NEONATAL INTENSIVE CARE UNIT (NICU) FOR INFANT:

☐ In an NICU for over 24 hours ☐ Not in an NICU

☐ In an NICU for less than 24 hours ☐ Unknown

CLIENT'S WEIGHT GAIN: ☐ Adequate, ☐ Inadequate, Actual:______________

PSYCHOSOCIAL RISK : Was client ever high risk during pregnancy: ☐ Yes, ☐ No

PRIMARY MEDICAL PROVIDER:

☐ Medical Doctor ☐ Physician's Assistant

☐ Certified Nurse Midwife ☐ Other:________________________

☐ Nurse Practitioner ☐ Unknown

* **UNITS OF SERVICE:** (from entry to outcome) Client=_____ EFM=_____ Partner=_____

Partner Present at Birth: ☐ Yes, ☐ No,

* **Client Participated in Preparation For Childbirth Classes:** ☐ Yes, ☐ No

* **Partner Participated in Preparation For Childbirth Classes:** ☐ Yes, ☐ No

* **PARTNER INVOLVEMENT:** (check all that apply)

☐ TAPP client ☐ Involved w/client ☐ Informal client ☐ Not involved

CLIENT STATUS CARD

Client's Name: ____________________ Entry Date: __________ ES: _____ CC: _____

Baby's Name: ____________________ DOB: __________

		7 mo.	1 yr.	2 yr.	3 yr.
1. Current Age:	1.				
2. Psychosocial Units:	2.				
3. Marital Status:	3.				
4. Pregnancy Status: (yes/no) (outcome)	4.				
5. Educational Status: (in/do/grad, where & grade)	5.				
6. Job Training Status: (in/comp/no) (where)	6.				
7. Employment: (-20/+20 hrs./LFW/no/where)	7.				
8. Welfare (yes/no) (p/in/nn) (specify type(s))	8.				
9. Medi-Cal (yes/no)	9.				
10. Living Arrangements:	10.				
11. Probation or Dependency: (yes/no) (300/600/601/602)	11.				
12. Health Care Site:	12.				

13. Paternity Estab.? 7 mo. ☐ 1 yr. ☐ 2 yr. ☐ 3 yr. ☐

INFANT STATUS CARD

Baby's Name: ____________________ DOB: __________ CC: _____

Client's Name: ____________________ Partner's Name: ____________________

		7 mo.	1 yr.	2 yr.	3 yr.
1. Infant Death: (yes/no) (cause)	1.				
2. Intensive Care Unit: (yes/no) (length of time)	2.				
3. Infant Lives with:	3.				
4. Suspected Abuse/Neglect:	4.				
5. Protective Service Referral: (explain)	5.				
6. Dependency: (yes/no)	6.				
7. Handicap: (specify)	7.				
8. Pediatric Care Site:	8.				
9. Child Care Arrangements:	9.				
10. Immunizations: (yes/no)	10.				
11. Developmental Milestones:	11.				

BEST COPY AVAILABLE